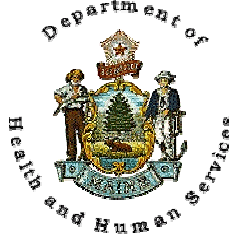


John Elias Baldacci
Governor



John R. Nicholas
Commissioner

Maine Department of Health and Human Services
11 State House Station
Augusta, Maine 04333-0011
Bureau of Medical Services

September 9, 2004

TO: Interested Parties
FROM: Christine Zukas-Lessard, Acting Director, Bureau of Medical Services
SUBJECT: Proposed Rule: Chapters II & III, Section 96, Private Duty Nursing & Personal Care Services, MaineCare Benefits Manual

This letter provides notice of the proposed rule: Chapters II & III, Section 96, Private Duty Nursing & Personal Care Services, which is available online at <http://www.maine.gov/bms/MaineCareBenefitManualRules.htm>.

In Chapter III, this rule proposes to add new procedure codes and delete a few procedure codes. Some reimbursement rates for nursing services are restructured and some rates for other services are reduced. Proposed changes for Chapter II include: reduced hourly caps for IADL services; "special circumstances nursing" which will allow a relative, under certain conditions, to be paid for providing nursing services to a family member; new requirements are added for billing nursing services when delivered to multiple patients during the same visit to the same location; a new "family provider option" will allow, under certain conditions, a member (or a family member) to manage his or her own personal care services; new requirements for criminal background checks are incorporated; and a new Level VIII will cover nursing services only for members who already receive personal care services under other Sections of the MaineCare Benefits Manual. The IADL portion of Appendix #1 is deleted. An Appendix # 2 that specifies the financial cap for each level-of-care is proposed.

Please refer to the attached Notice of Rule-Making Proposal for the date and location of the scheduled public hearing, as well as the agency contact person and address for submitting written comments on this rule.

This rule is available on the Bureau of Medical Services website at <http://www.maine.gov/bms/MaineCareBenefitManualRules.htm> or, for a fee, interested parties may request a paper copy of the rule by calling 207-287-9368. The TDD/TTY number is: (207) 287-1828 or 1-800-423-4331.

Notice of Agency Rule-making Proposal

AGENCY: Department of Health and Human Services (DHHS), Bureau of Medical Services

RULE TITLE OR SUBJECT: Chapters II & III, Section 96, Private Duty Nursing & Personal Care Services, MaineCare Benefits Manual.

PROPOSED RULE NUMBER

CONCISE SUMMARY: PL 2004 C.673, Sec. MMM provides for limiting benefits and reducing rates of reimbursement for Private Duty Nursing Services to achieve \$233,333 in savings for the General Fund for SFY 05. Chapter III proposes new procedure codes and some restructured reimbursement rates, as well as reduced rates for other services. Changes for Chapter II include: reduced hourly caps for IADL services; “special circumstances nursing” will allow a relative, under certain conditions, to be paid for providing nursing services to a family member; new requirements are added for billing nursing services when delivered to multiple patients during the same visit to the same location; a new “family provider option” will allow, under certain conditions, a member (or a family member) to manage his or her own personal care services; new requirements for criminal background checks are incorporated; and a new Level VIII will cover nursing services only for members who already receive personal care services under other Sections of the MaineCare Benefits Manual. The IADL portion of Appendix #1 is deleted. An Appendix # 2 that specifies the financial cap for each level-of-care is proposed.

See <http://www.maine.gov/bms/MaineCareBenefitManualRules.htm> for rules and related rulemaking documents.

THIS RULE WILL __ WILL NOT _XX_ HAVE A FISCAL IMPACT ON MUNICIPALITIES.

STATUTORY AUTHORITY: 22 M.R.S.A., §42, §3173

PUBLIC HEARING (IF ANY, GIVE DATE, TIME, LOCATION): October 6, 1:00 pm, Room #1A, Bureau of Medical Services, DHHS, 442 Civic Center Drive, Augusta, ME 04333

DEADLINE FOR COMMENTS:

Written comments will be accepted through October 18, 2004.

AGENCY CONTACT PERSON: Julie Tosswill

AGENCY NAME: Policy and Provider Services, Bureau of Medical Services

ADDRESS: 11 State House Station

442 Civic Center Drive

Augusta, Maine 04333-0011

TELEPHONE: 287-9360 or 1-800-321-5557 option 9

Deaf/ Hard of Hearing TTY# 287-1828 or TTY# 1-800-423-4331

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96.01 DEFINITIONS

- 96.01-1 "Private Duty Nursing (PDN) and Personal Care Services (PCS)" are those covered services provided to an eligible member, as defined in this Section, when determined to be medically necessary, when prior authorized, and in the best interest of the member according to the orders and written plan of care reviewed and signed by a licensed physician. Except as described in Section 96.03, all services provided are not to exceed the cost limits set forth in Section 96.03.
- 96.01-2 "Covered Services" are those services for which payment can be made under Title XIX or XXI by the Department of Health and Human Services.
- 96.01-3 "Private Duty Nursing Services" are those services ~~that which~~ are provided by a registered nurse and/or a licensed practical nurse, in accordance with the Board of Nursing Regulations, under the direction of the member's physician, to a member in his or her place of residence or outside the member's residence, when required life activities take the member outside his or her residence (school, preschool, daycare, medical appointments, etc.). Reimbursement for services provided outside a member's residence ~~can shall~~ include only authorized nursing services and authorized personal care services ~~authorized IADLs only and shall may~~ not exceed that which would have been allowed strictly in a home setting. For purposes of this Section, "place of residence" does not include such institutional settings as nursing facilities, intermediate care facilities for persons with mental retardation (ICFs-MR), or hospitals. If nursing services are covered under a private non-medical institution's per diem rate, then ~~for~~ Levels II, III, VI, VII; private duty nursing services are not allowed under this Section.
- 96.01-4 "Personal Care Services" are those Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL) services provided ~~in to~~ a member's ~~residence~~ by a home health aide, certified nursing assistant or a personal care assistant (also known as a personal support specialist), as appropriate, while completing tasks in accordance with an authorized plan of care. Under this Section, personal care services are not covered in the following settings: For the purpose of this Section, place of residence does not include such institutional settings as nursing facilities, intermediate care facilities for persons with mental retardation, or hospitals, adult family care homes, or assisted living facilities. If personal care services are covered under a private non-medical institution's per diem rate, then ~~for~~ Levels I, II, III, VI, VII; personal care services are not allowed under this Section.
- 96.01-5 A "Unit of Service" is a reimbursable unit of direct service as specified in Chapter III of this Section. A unit of service requires personal contact in or outside the member's place of residence made for the purpose of providing a covered service. When two or more persons provide separate and distinct types of services simultaneously, each must be recorded separately.
- 96.01-6 "Average Monthly Cost" is one twelfth of the average annual cost as defined by the Department of Health and Human Services. The costs of MaineCare physical therapy, occupational therapy, speech and hearing services and medical social worker services shall not be included in the calculation of this average monthly cost.
- 96.01-7 "Cuing" ~~shall~~ means any spoken instruction or physical guidance which serves as a signal to do something. Cuing is typically used when caring for individuals who are cognitively impaired.

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96.01 **DEFINITIONS** (cont)

- 96.01-8 Limited Assistance is a term used to describe an individual's self-care performance in activities of daily living, as defined by the Minimum Data Set (MDS) assessment process. It means that although the individual was highly involved in the activity over the last 7 days, or 24 to 48 hours if in a hospital setting, help of the following type(s) was provided:
- Guided maneuvering of limbs or other non-weight-bearing assistance three or more times, or
 - Guided maneuvering of limbs or other non-weight-bearing assistance three or more times plus weight-bearing support provided only one or two times.
- 96.01-9 One-person Physical Assist requires one person to provide either weight-bearing or non-weight-bearing assistance for an individual who cannot perform the activity independently over the last 7 days, or 24 to 48 hours if in a hospital setting. This does not include cuing.
- 96.01-10 Extensive Assistance means although the individual performed part of the activity over the last 7 days, or 24 to 48 hours if in a hospital setting, help of the following type(s) was provided:
- Weight-bearing support three or more times, or
 - Full staff performance during part (but not all) of the last 7 days.
- 96.01-11 Total Dependence means full staff performance of the activity during the entire previous 7 day period across all shifts, or during each 8 hour period in 24 hours.
- 96.01-12 Significant Change means a major change in the member's status that is not self limiting, impacts on more than one area of functional or health status, and requires multi-disciplinary review or revision of the plan of care. A significant change assessment is appropriate if there is a consistent pattern of change with either two or more areas of improvement, or two or more areas of decline.
- 96.01-13 Assessing Services Agency (ASA). For all members age 21 and over and those under age 21 receiving care under the family provider services option, and excluding those members classified for medication or venipuncture services under this Section, the ASA is authorized to conduct face-to-face assessments, using the Department's Medical Eligibility Determination (MED) form, and the timeframes and definitions contained therein, to determine medical eligibility for covered services. Based upon a member's assessment outcome scores recorded in the MED form, the ASA is responsible for authorizing a plan of care, which ~~must~~shall specify all services to be provided under this Section, including the number of hours for services, and the provider types. The ASA is the Department's Authorized Agent for medical eligibility determinations, care plan development, and authorization of covered services under this Section.
- 96.01-14 Authorized Agent ~~shall~~ means an organization authorized by the Department to perform functions under a valid contract or other approved, signed agreement. The Assessing Services Agency (ASA) and the Home Care Coordinating Agency (HCCA) are Authorized Agents under this Section.

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96.01 **DEFINITIONS (cont)**

- 96.01-15 Home Care Coordinating Agency (HCCA). For all members age 21 and over and those members under age 21 receiving services under the family provider services option, and excluding those members classified for medication services or venipuncture services under this Section, the HCCA is responsible for a range of activities, which includes the following: coordinate and implement the services in the member's plan of care authorized by the ASA; ensure that authorized services are delivered according to the service authorizations; reduce, deny, or terminate services under this Section; serve as a resource to members and their families to identify available service options and service providers; answer questions; and assist with resolving problems. The HCCA is also responsible for administrative functions, including: maintaining member records; processing claims; overseeing and assuring compliance with policy requirements by any and all sub-contractors and conducting required utilization review activities.
- ~~96.01-16 Health Assessment must be conducted by a PDN registered nurse for Level II and III members, and is a required component of the monthly nursing service under this Section unless otherwise specified in Section 96.04(B). The assessment will shall be used for the management of chronic, stable conditions. The assessment must include the following components; physical vital signs, weight (if the member is confined to a bed so that a weight measurement cannot be readily obtained by the nurse, this measurement may be postponed, observable weight changes should be noted), comprehensive systems review, nutritional status, medication review and compliance, health advice, environmental and social needs. The nurse must shall communicate and follow up with the physician and/or other providers as necessary. The health assessment must be forwarded to the HCCA for members age 21 and over. For members under age 21 the health assessment is shall be maintained by the provider in the record. A health assessment is not a covered service for Level I members.~~
- 96.01-176 Contraindicated ~~shall~~ means the member's condition renders some particular line of treatment improper or undesirable.
- 96.01-187 Medical Eligibility Determination (MED) Form ~~shall~~ means the form approved by the Department for medical eligibility determinations and service authorization for the plan of care based upon the assessment outcome scores. The definitions, scoring mechanisms and time-frames relating to this form are outlined in Section 96.02-4 and provide the basis for services and the care plan authorized by the ASA. The care plan summary contained in the MED form documents the authorized service plan. The care plan summary also identifies other services the member is receiving, in addition to the authorized services provided under this Section. For all members age 21 and over, and those under age 21 receiving care under the family provider services option, and excluding those classified for medication services or venipuncture services under this Section, the Assessing Services Agency (ASA) ~~shall~~ has the authority to conduct the medical eligibility determination. For all members under age 21, excluding those receiving care under the family provider option, and for all those classified for medication services or venipuncture services under this Section, the PDN provider ~~shall~~ conducts the medical eligibility determination.
- 96.01-198 Authorized Plan of Care ~~shall~~ means a plan of care that which is authorized by the Assessing Services Agency, or the Department, which shall specify all services to be ~~D~~delivered to a

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96.01 **DEFINITIONS (cont)**

member under this Section, including the number of hours for all covered services. The plan of care ~~must~~ shall be based upon the member's assessment outcome scores recorded in the Department's medical eligibility determination form. For all members age 21 and over, and those under age 21 receiving care under the family provider services option, and excluding those classified for medication services or venipuncture services under this Section, the Assessing Services Agency (ASA) has the authority to determine and authorize the plan of care. All authorized and covered services provided under this Section must be listed in the care plan summary on the MED form.

96.01-~~2019~~ Activities of Daily Living (ADL): The only ADLs that will be considered for the purpose of determining eligibility are:

- (i) Bed Mobility: How person moves to and from lying position, turns side to side, and positions body while in bed;
- (ii) Transfer: How person moves between surfaces to/from: bed, wheelchair, standing position (excluding to/from bath/toilet);
- (iii) Locomotion: How person moves between locations, in room and other areas. If in wheelchair, self-sufficiency once in chair;
- (iv) Eating: How person eats and drinks (regardless of skill);
- (v) Toilet Use: How person uses the toilet room (or commode, bedpan, urinal), transfers on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes;
- (vi) Bathing: How person takes full-body bath/shower, sponge bath and transfers in/out of tub/shower (exclude washing of back and hair); and
- (vii) Dressing: How person puts on, fastens, and takes off all items of street clothing, including donning/removing prosthesis.

96.01-~~240~~ Instrumental Activities of Daily Living (IADL); For the purpose of determining eligibility, IADLs ~~shall~~ include only the following: main meal preparation; routine housework; grocery shopping and storage of purchased groceries; and laundry either within the residence or at an outside laundry facility.

96.01-~~221~~ Unstable: A medical condition is unstable when it is fluctuating in an irregular way and/or is deteriorating and affects the member's ability to function independently. The fluctuations are to such a degree that medical treatment and professional nursing observation, assessment and management at least once every 8 hours is required. An unstable medical condition requires increased physician involvement and should result in communication with the physician for adjustments in treatment and medication. Evidence of fluctuating vital signs, lab values, and physical symptoms and plan of care adjustments must be documented in the medical record. ~~Not included in this definition, is -~~ The loss of function resulting from a temporary disability from which full recovery is expected, does not constitute an unstable medical condition.

96.01-~~232~~ Health Maintenance Activities are activities to assist the member with Activities of Daily Living and Instrumental Activities of Daily Living, and additional activities specified in this definition. These activities are performed by a designated caregiver for an individual who would otherwise perform the activities, if he or she were physically or cognitively able to do so and enable the individual to live in his or her home and community. These additional

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96.01 **DEFINITIONS** (cont)

activities include, but are not limited to, catheterization, ostomy care, preparation of food and tube feedings, bowel treatments, administration of medications, care of skin with damaged integrity, occupational and physical therapy activities such as assistance with prescribed exercise regimes.

96.01-23 Family Provider Service Option is an option available to certain eligible members that allows the member to manage his or her own personal care services. The management includes: hiring, firing, training, maintaining records and scheduling the personal care assistant(s). If the MaineCare member does not have the ability or does not desire to manage his or her own care, a family member related by blood, marriage or adoption, or a significant other in a committed partnership, can manage the personal care services on the member's behalf. To use the family provider service option, the MaineCare member, or his or her family member, as applicable, must be a family provider agency.

96.01-24 Family Provider Agency is a State-registered personal care services agency that manages personal care services for up to two members of a given family, under the family provider service option.

96.01-25 Fiscal Intermediary (FI) is an organization that provides administrative and payroll services on behalf of a family provider agency for the services of personal care assistants under the family provider service option. FI services include, but are not limited to, preparing payroll and withholding taxes, making payments to suppliers of goods and services and ensuring compliance with State and Federal tax and labor regulations and the requirements under this Section.

96.01-26 Cognitive Capacity. A member's cognitive capacity is determined during the MED assessment process conducted by the ASA RN assessor. For purposes of this Section, sufficient cognitive capacity is established by any combination of the MED scores specified below for all of the following items:

- A. decision making skills: a score of 0 or 1; and
- B. making self understood: a score of 0, 1, or 2; and
- C. ability to understand others: a score of 0, 1, or 2; and
- D. self performance of managing finances: a score of 0, 1, or 2; and
- E. support for managing finances: a score of 0, 1, 2, or 3.

96.02 **ELIGIBILITY FOR CARE**

96.02-1 **General and Specific Requirements**

An individual is eligible to receive services as set forth in this Section if he or she meets the general MaineCare eligibility requirements, the specific MaineCare eligibility requirements, and the medical eligibility requirements.

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96.02 **ELIGIBILITY FOR CARE** (cont)

96.02-2 **General MaineCare Eligibility Requirements**

Individuals must meet the financial eligibility criteria as set forth in the MaineCare Eligibility Manual. Some members may have restrictions on the type and amount of services they are eligible to receive.

96.02-3 **Specific Eligibility Requirements**

- A. Only individuals under age 21 are eligible for Level IV under this Section.
- B. Individuals of any age are eligible for other levels of care.

96.02-4 **Medical Eligibility Requirements**

Applicants for services under this Section must meet the eligibility requirements as set forth in this Section and as documented on the Medical Eligibility Determination (MED) form. A member meets the medical eligibility requirements for a particular level of care if he or she requires a combination of assistance with the required numbers of Activities of Daily Living and nursing services, as appropriate. The requirements for each level of care are defined below. The clinical judgment of the Department's Assessing Services Agency shall be the basis of the scores entered on the Medical Eligibility Determination form.

Medical eligibility and the scores for criteria: (l) extensive assistance or total dependence, (m) behavior and (n) cognition, as well as, the Activities of Daily Living and the Instrumental Activities of Daily Living, must be reviewed in the context of an individual's age-appropriate development. A child or infant shall not qualify for covered services by virtue of scoring high dependency requirements with the ADLs or IADLs, or the aforementioned criteria, when these dependency requirements are normal for the child's age. The clinical judgment of the Department's Assessing Services Agency, or the PDN provider as required (for individuals under age 21), shall be determinative of the scores on the medical eligibility determination assessment.

Determination of Eligibility

A registered nurse trained in conducting assessments with the Department's approved MED form, shall conduct the medical eligibility assessment. In the process of completing the assessment the nurse assessor shall use professional nursing judgment. The assessor shall, as appropriate within the exercise of professional nursing judgment, consider documentation, perform observations, and conduct interviews with the applicant/member, family members, direct care staff, the applicant's/member's physicians, and other individuals and document in the record of the assessment all information considered relevant in his or her professional judgment.

A. **Level I**

A member meets the medical eligibility requirements for Level I if he or she requires:

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96.02 **ELIGIBILITY FOR CARE** (cont)

1. cuing seven (7) days per week for eating, toilet use, bathing, and dressing; **OR**
2. limited assistance and a one person physical assist with at least two (2) ADLs; **OR**
3. limited assistance and a one person physical assist with at least one (1) ADL plus physical assistance with at least two (2) IADLs; **OR**
4. any of the following nursing services, at least once per month, that are or otherwise would be performed by or under the supervision of a registered professional nurse:
 - a. intraarterial, intravenous, intramuscular, or subcutaneous injection, or intravenous feeding, for treatment of unstable conditions requiring medical or nursing intervention; other than daily insulin injections for an individual whose diabetes is under control;
 - b. nasogastric tube, gastrostomy, or jejunostomy feeding, for a new/recent (within past 30 days) or unstable condition;
 - c. nasopharyngeal suctioning or tracheostomy care; however, care of a tracheostomy tube must be for a recent (within the last thirty (30) days) or unstable condition;
 - d. treatment and/or application of dressings when the physician has prescribed irrigation, the application of prescribed medication, or sterile dressings of stage III and IV decubitus ulcers, other widespread skin disorders (except psoriasis and eczema), or care of wounds, when the skills of a registered nurse are needed to provide safe and effective services (including, but not limited to, ulcers, 2nd or 3rd degree burns, open surgical sites, fistulas, tube sites, and tumor erosions);
 - e. administration of oxygen on a regular and continuing basis when the member's medical condition warrants professional nursing observations, for a new or recent (within past 30 days) condition;
 - f. insertion and maintenance of a urethral or suprapubic catheter as an adjunct to the active treatment of a disease or medical condition may justify a need for skilled nursing care. In such instances, the need for a catheter must be documented and justified in the member's medical record;
 - g. services to manage a comatose condition;
 - h. care to manage conditions requiring a ventilator/respirator;
 - i. direct assistance from others is required for the safe management of an uncontrolled seizure disorder, (i.e. grand mal);

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96.02 **ELIGIBILITY FOR CARE** (cont)

- j. professional nursing assessment, observation, and management for problems including wandering, or physical abuse, or verbal abuse or socially inappropriate behavior;
- k. professional nursing assessment, observation and management for impaired memory, and impaired recall ability, and impaired cognitive ability;
- l. administration of treatments, procedures, or dressing changes which involve prescription medications, for post-operative or chronic conditions according to physician orders, that require nursing care and monitoring. Treatments include:
 - 1. administration of medication via a tube;
 - 2. tracheostomy care;
 - 3. urinary catheter change;
 - 4. urinary catheter irrigation;
 - 5. barrier dressings for Stage 1 or 2 ulcers;
 - 6. chest PT by RN;
 - 7. oxygen therapy by RN;
 - 8. other physician ordered treatments; or
 - 9. teaching and training activities for patient and family.
- m. professional nursing for physician ordered radiation therapy, chemotherapy, or dialysis.

B. Level II

A person meets the medical eligibility requirements for Level II, if he or she meets the criteria for requiring (B)(1) nursing services and assistance with (B)(2) activities of daily living as described below:

1. **Nursing Services**

To meet the nursing services criteria, a person must need any of the following services, at least once per month, that are or otherwise would be performed by or under the supervision of a registered professional nurse, as described below:

- a. intraarterial, intravenous, intramuscular, or subcutaneous injection, or intravenous feeding, for treatment of unstable conditions requiring medical or nursing intervention; other than daily insulin injections for an individual whose diabetes is under control;
- b. nasogastric tube, gastrostomy, or jejunostomy feeding, for a new/recent (within past 30 days) or unstable condition;

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96.02 ELIGIBILITY FOR CARE (cont)

- c. nasopharyngeal suctioning or tracheostomy care; however, care of a tracheostomy tube must be for a recent (within the last thirty (30) days) or unstable condition;
- d. treatment and/or application of dressings when the physician has prescribed irrigation, the application of prescribed medication, or sterile dressings of stage III and IV decubitus ulcers, other widespread skin disorders (except psoriasis and eczema), or care of wounds, when the skills of a registered nurse are needed to provide safe and effective services (including, but not limited to, ulcers, 2nd or 3rd degree burns, open surgical sites, fistulas, tube sites, and tumor erosions);
- e. administration of oxygen on a regular and continuing basis when the member's medical condition warrants professional nursing observations, for a new or recent (within past 30 days) condition;
- f. professional nursing assessment, observation and management of a medical condition;
- g. insertion and maintenance of a urethral or suprapubic catheter as an adjunct to the active treatment of a disease or medical condition may justify a need for skilled nursing care. In such instances, the need for a catheter must be documented and justified in the member's medical record;
- h. services to manage a comatose condition;
- i. care to manage conditions requiring a ventilator/respirator;
- j. direct assistance from others is required for the safe management of an uncontrolled seizure disorder, (i.e. grand mal);
- k. professional nursing assessment, observation, and management for problems including wandering, or physical abuse, or verbal abuse or socially inappropriate behavior;
- l. professional nursing assessment, observation and management for impaired memory, and impaired recall ability, and impaired cognitive ability;
- m. administration of treatments, procedures, or dressing changes which involve prescription medications, for post-operative or chronic conditions according to physician orders, that require nursing care and monitoring;
 - 1. administration of medication via a tube;
 - 2. tracheostomy care;
 - 3. urinary catheter change;

96.02 **ELIGIBILITY FOR CARE** (cont)

4. urinary catheter irrigation;
 5. barrier dressings for Stage 1 or 2 ulcers;
 6. chest PT by RN;
 7. oxygen therapy by RN;
 8. other physician ordered treatments; or
 9. teaching and training activities for patient and family.
 - n. professional nursing for physician ordered radiation therapy, chemotherapy, or dialysis.
2. Activities of Daily Living:

An individual must require daily (7 days per week) "cuing" for all of the following ADLs: eating, toilet use, bathing, dressing; or, at least "limited assistance" and a "one person physical assist" is needed with at least any two activities of daily living.

C. Level III

1. A person meets the medical eligibility requirements for Level III if he or she requires at least "limited assistance" and a "one person physical assist" with two of the following ADLs: bed mobility, transfer, locomotion, eating, or toileting, and if he or she meets the criteria for nursing services below.
2. To meet the nursing services criteria, a person must need any of the following services, at least once per month, that are or otherwise would be performed by, or under the supervision of, a registered professional nurse, as described below:
 - a. intraarterial, intravenous, intramuscular, or subcutaneous injection, or intravenous feeding, for treatment of unstable conditions requiring medical or nursing intervention, other than daily insulin injections for an individual whose diabetes is under control;
 - b. nasogastric tube, gastrostomy, or jejunostomy feeding, for a new/recent (within the last thirty (30) days) or unstable condition;
 - c. nasopharyngeal suctioning or tracheostomy care; however, care of a tracheostomy tube must be for a recent, (within the last thirty (30) days) or unstable condition;
 - d. treatment and/or application of dressings when the physician has prescribed irrigation, the application of prescribed medication, or sterile dressings of stage III and IV decubitus ulcers, other widespread skin

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96.02 **ELIGIBILITY FOR CARE** (cont)

- disorders (except psoriasis and eczema), or care of wounds, when the skills of a registered nurse are needed to provide safe and effective services (including, but not limited to, ulcers, 2nd or 3rd degree burns, open surgical sites, fistulas, tube sites, and tumor erosions);
- e. administration of oxygen on a regular and continuing basis when the member's medical condition warrants professional nursing observations, for a new or recent (within last thirty (30) days) condition;
 - f. professional nursing assessment, observation and management of a medical condition;
 - g. insertion and maintenance of a urethral or suprapubic catheter as an adjunct to the active treatment of a disease or medical condition may justify a need for skilled nursing care. In such instances, the need for a catheter must be documented and justified in the member's medical record;
 - h. services to manage a comatose condition;
 - i. care to manage conditions requiring a ventilator/respirator;
 - j. direct assistance from others is required for the safe management of an uncontrolled seizure disorder, (e.g. grand mal);
 - k. professional nursing assessment, observation, and management for problems including wandering, or physical, or verbal abuse, or socially inappropriate behavior;
 - l. professional nursing assessment, observation and management for impaired memory, and impaired recall ability, and impaired cognitive ability;
 - m. administration of treatments, procedures, or dressing changes that involve prescription medications for post-operative or chronic conditions according to physician orders and require nursing care and monitoring; or
 - n. professional nursing for physician ordered radiation therapy, chemotherapy, or dialysis.

D. Level IV

An individual who is under 21 years of age is eligible for Level IV, if he or she meets the medical eligibility requirements set forth in Section 67.02-3, Nursing Facility Services, of the MaineCare Benefits Manual.

96.02 **ELIGIBILITY FOR CARE** (cont)

E. Level V

A person meets the medical eligibility requirements for Level V if he or she requires either (1) or (2) below.

1. Daily (7 days per week) nursing services and ventilator support for a ventilator-dependent person.

OR

2. a. Daily (7 days per week), twenty-four (24) hour nursing care for at least one of the following treatments and procedures: 96.02-4(B)(1)(a); (b); (c); (d); (h) or (j); required every eight (8) hours (or all three (3) shifts), which are, or otherwise would be, performed by an RN or LPN;

AND

- b. Daily (7 days per week) nursing care for at least any two (2) of the following professional nursing services: 96.02-4(B)(1)(a); (b); (c); (d); (h); or (j).

F. Level VI Medication and Venipuncture Services for Severely Mentally Disabled Members.

An individual meets the medical eligibility requirements for Level VI if the following are met:

1. The individual meets the eligibility requirements for services under Section 17, Community Support Services for Persons with Severe and Disabling Mental Illness, and requires medication administration or monitoring services for the treatment of mental illness. The member's eligibility shall be established by a completed "verification of eligibility form" described in Section 17, or otherwise by a signed certification by a physician that the member is eligible/covered under Section 17. Dated copies of this form/certification must be maintained in the member's record to verify eligibility for covered services.

AND

2. A physician must sign and certify a statement that the member's medical condition prevents the safe use of outpatient services and outpatient services are contraindicated for specific reasons. The reasons must be listed and the likelihood of such a bad result must be probable or definite as opposed to possible or rare. Reasons may include lack of services within a twenty (20) mile radius of the member's residence. MaineCare covers transportation to all MaineCare covered services, therefore, lack of transportation does not qualify as an exemption.

96.02 ELIGIBILITY FOR CARE (cont)

G. Level VII Venipuncture Only Services

An individual meets the medical eligibility requirements for Level VII if the following are met:

1. The individual requires only venipuncture services on a regular basis, as ordered by a physician.

AND

2. A physician must sign and certify a statement that the member's medical condition prevents the safe use of outpatient services and outpatient services are contraindicated for specific reasons. The reasons must be listed and the likelihood of such a bad result must be probable or definite as opposed to possible or rare. Reasons may include lack of services within a twenty (20) mile radius of the member's residence. MaineCare covers transportation to all MaineCare covered services, therefore, lack of transportation does not qualify as an exemption.

H. Level VIII Nursing Services Only for Members receiving Personal Care Services under other Sections of the MBM. A member meets the requirements for Level VIII if he or she is receiving personal care services under any of the following Sections: Section 2, Adult Family Care Services; Section 6, Assisted Living Services; Section 12, Consumer Directed Attendant Care Services; Section 22, Home and Community Benefits for the Physically Disabled; Section 97, Private Non-Medical Institution Services; and Section 21, Home and Community-Based Waiver Services for Members with Mental Retardation, and requires any of the following nursing services, at least once per month, that are or otherwise would be performed by or under the supervision of a registered professional nurse:

- a. intraarterial, intravenous, intramuscular, or subcutaneous injection, or intravenous feeding, for treatment of unstable conditions requiring medical or nursing intervention; other than daily insulin injections for an individual whose diabetes is under control;
- b. nasogastric tube, gastrostomy, or jejunostomy feeding, for a new/recent (within past 30 days) or unstable condition;
- c. nasopharyngeal suctioning or tracheostomy care; however, care of a tracheostomy tube must be for a recent (within the last thirty (30) days) or unstable condition;
- d. treatment and/or application of dressings when the physician has prescribed irrigation, the application of prescribed medication, or sterile dressings of stage III and IV decubitus ulcers, other widespread skin disorders (except psoriasis and eczema), or care of wounds, when the skills

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96.02 **ELIGIBILITY FOR CARE** (cont)

of a registered nurse are needed to provide safe and effective services (including, but not limited to, ulcers, 2nd or 3rd degree burns, open surgical sites, fistulas, tube sites, and tumor erosions);

- e. administration of oxygen on a regular and continuing basis when the member's medical condition warrants professional nursing observations, for a new or recent (within past 30 days) condition;
- f. insertion and maintenance of a urethral or suprapubic catheter as an adjunct to the active treatment of a disease or medical condition may justify a need for skilled nursing care. In such instances, the need for a catheter must be documented and justified in the member's medical record;
- g. services to manage a comatose condition;
- h. care to manage conditions requiring a ventilator/respirator;
- i. direct assistance from others is required for the safe management of an uncontrolled seizure disorder, (i.e. grand mal);
- j. (this item does not apply to members residing in assisted living facilities) professional nursing assessment, observation, and management for problems including wandering, or physical abuse, or verbal abuse or socially inappropriate behavior;
- k. (this item does not apply to members living in assisted living facilities) professional nursing assessment, observation and management for impaired memory, and impaired recall ability, and impaired cognitive ability;
- l. administration of treatments, procedures, or dressing changes which involve prescription medications, for post-operative or chronic conditions according to physician orders, that require nursing care and monitoring. Treatments include:
 - 1. administration of medication via a tube;
 - 2. tracheostomy care;
 - 3. urinary catheter change;
 - 4. urinary catheter irrigation;
 - 5. barrier dressings for Stage 1 or 2 ulcers;
 - 6. chest PT by RN;
 - 7. oxygen therapy by RN;
 - 8. other physician ordered treatments; or
 - 9. teaching and training activities for patient and family.
- m. professional nursing for physician ordered radiation therapy, chemotherapy, or dialysis.

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96.03 **DURATION OF CARE**

Each Title XIX and XXI member may receive as many covered services as are medically necessary within the following limitations and exceptions as described below. MaineCare coverage of services under this Section requires prior authorization from the Department or its Assessing Services Agency. Beginning and end dates of an individual's medical eligibility determination period correspond to the beginning and end dates for MaineCare coverage of the plan of care authorized by the ASA or the Department.

- A. Exception to the Limit: For all individuals under the age of 21 years, the caps described below may be exceeded if services beyond these levels are determined medically necessary pursuant to the criteria described in Prevention, Health Promotion and Optional Treatment Services, formerly EPSDT, of the MaineCare Benefits Manual. A determination of medical necessity for PDN/PCS shall not be determinative of medical necessity under Prevention, Health Promotion and Optional Treatment Services. These additional services do not require prior authorization by the Department, however, there must be sufficient documentation related to all services and services may be subject to review and action by the Surveillance and Utilization Review Unit.

Limits (when applicable) for individuals under age 21 years shall be based upon a yearly cap to better serve children who have episodic service needs.

- B. Except as described in (A) above, for individuals classified for Levels of care I, II, ~~or III, or VIII~~, ~~of care~~ the total monthly cost of covered private duty nursing, and personal care services, either alone or in combination with home health services provided under Chapters II & III, Section 40 of the MaineCare Benefits Manual, may not exceed the monthly Level I, II, ~~and III, and VIII~~ caps established by the Department and the plan of care authorized by the ASA on the MED form. The amount of services an individual member is authorized to receive is based upon the member's MED assessment outcome scores. The Level I, II, ~~and III, and VIII~~ caps are tied to allowing coverage for a range of services to meet the medical and excluding Level VIII, personal care service needs of each level.
- C. Except as described in (A) above, for individuals classified for Level IV of care, the total cost of private duty nursing and personal care services, either alone or in combination with home health services provided under Chapters II & III, Section 40 of the MaineCare Benefits Manual, may not exceed 100% of the ~~Department's~~ average MaineCare annual cost of NF institutional services.
- D. Except as described in (A) above, for all individuals who are determined medically eligible for Level V care, the total monthly cost of private duty nursing and personal care services, either alone or in combination with home health services provided under Chapters II & III, Section 40 of the MaineCare Benefits Manual, may not exceed the monthly Level V cap established by the Department. The Department reserves the right to request additional information to evaluate medical necessity.
- E. Services under this Section may be denied, reduced or terminated by the Department, its Authorized Agent, or the PDN provider, as appropriate, for the following reasons:
1. A significant change occurs in the member's medical status such that an authorized plan of care under this Section can no longer be developed; or

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96.03 **DURATION OF CARE** (cont)

2. The member becomes an inpatient of a hospital, nursing facility, ICF-MR; or
 3. The member is not medically eligible to receive services under this Section or financially eligible to receive Title XIX or XXI benefits; or
 4. Based upon the most recent MED assessment, the plan of care service authorization may be reduced to match the member's needs as identified in the reassessment and subject to the limitations of the service program cap, as follows:
 - a. for members age 21 and over, and those under age 21 receiving care under the family provider services option, and excluding those classified for medication services or venipuncture services under this Section according to the clinical judgment of the Department, the ASA or HCCA;
 - b. for members under age 21, as well as those classified for medication services or venipuncture services under this Section, by the Department or the PDN provider; but excluding those receiving care under the family provider services option; or
 5. The member declines services; or
 6. The member refuses personal care or nursing services; or
 7. The health or safety of individuals providing services is endangered. The Department, ASA, or the provider documents that the member, or someone living in or frequently visiting the household, harasses, threatens, or endangers the health or safety of individuals delivering services; or
 8. The member begins receiving any of the following MaineCare services: Section 2, Adult Family Care Services; Section 6, Assisted Living Services; Section 12, Consumer Directed Attendant Care Services; Section 22, Home and Community Benefits for the Physically Disabled; Section 97, Private Non-Medical Institution Services; and Section 21, Home and Community-Based Waiver Services for Members with Mental Retardation, in which case the personal care services are not covered under this Section.
- F. Suspension. Services may be suspended for up to thirty (30) days while the member is hospitalized or using institutional care. If such circumstances extend beyond thirty (30) days, the member's service coverage will be terminated and the member will need to be reassessed to determine medical eligibility for these services.

Services may also be suspended for a member who requires Section 40, Home Health Services. Home health services and services under this Section must not duplicate one another.

96.04 COVERED SERVICES

Covered services are available for individuals meeting the eligibility requirements set forth in Section 96.02. Covered services must be required in order to maintain the member's current health status, or prevent or delay deterioration of a member and/or delay long-term institutional care. These services require prior authorization by the Department, or its Assessing Services Agency and are subject to the limits in Section 96.03.

Services provided must be reasonable and necessary for meeting the medical needs of the individual, based upon the medical record, and upon the outcome scores on the MED form, and as authorized in the plan of care. Coverage will be denied if the services provided are not consistent with the member's authorized plan of care. The Department may also recoup payment for inappropriate service provision, as determined through post payment review.

For members age 21 and over, and those under age 21 receiving care under the family provider option, and excluding those classified for medication services or venipuncture services under this Section, the Assessing Services Agency (ASA) has the authority to determine the plan of care, which shall specify all services to be provided, including the number of hours for each covered service.

For members under age 21 at any level of service, as well as Level VI and Level VII members, but excluding those receiving care under the family provider option, the PDN provider shall establish a plan of care. The plan of care shall be based upon the member's assessment outcome scores recorded in the Department's Medical Eligibility Determination (MED) form and the timeframes therein.

Section 40, Home Health Services, shall not replace or be delivered and reimbursed in lieu of authorized Section 96 covered services. (Section 40, Home Health Services, must be delivered and reimbursed pursuant to those rules.) Covered services under this Section 96 include the following:

- A. Private Duty Nursing Services must be provided according to a written plan of care, reviewed and signed by a licensed physician, and available to the Department or the HCCA upon request. At least monthly nursing services must be delivered to all Level II and III members, as well as those Level I members who are eligible for services based upon the need for monthly nursing services.

For individuals age 21 and over, and those under age 21 receiving care under the family provider option, and excluding those classified for medication services or venipuncture services under this Section, private duty nursing services shall be authorized by the Assessing Services Agency, and ordered, monitored and reimbursed by the HCCA, in accordance with the authorized plan of care for covered services under this Section.

For individuals under age 21, as well as all individuals classified for venipuncture services or medication services for the severely mentally disabled, and excluding those receiving care under the family provider option, the Department shall classify the member based on the plan of care developed by the provider, subject to the process described under Section 96.06.

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96.04 COVERED SERVICES (cont)

Nursing services may be provided by:

1. an independently practicing registered professional nurse;
2. a registered professional nurse or licensed practical nurse employed by, or under contract with, a licensed home health agency.

Except as allowed in Section 96.04(B) below, Nursing services shall not be covered when provided by the member's husband or wife, natural or adoptive parent, child, or sibling, stepparent, stepchild, stepbrother or stepsister, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, grandparent or grandchild, spouse of grandparent or grandchild or any person sharing a common abode as part of a single family unit.

- B. "Special circumstances nursing" allows a relative, including a spouse or the parent of a minor child, to be paid to provide nursing services to the member under this Section. To qualify for this coverage the member's relative must meet the requirements in (1) and (2) below.

1. The relative must: (all of the following are required)

- a. meet all licensing, training, reporting and other requirements otherwise specified in this Section; and
- b. be employed by a licensed home health agency; and
- c. abide by the requirement that an independent nurse or physician must conduct any required assessments and/or develop the plan of care; and
- d. implement the member's authorized plan of care; and
- e. if applicable, expect to continue non-reimbursed family caregiver responsibilities; and
- f. pass a criminal background check. The family nursing provider must not have any criminal convictions, except for Class D and Class E convictions over 10 years old that did not involve as a victim of the act a patient, client, or resident of a health care entity; or any specific documented findings by the State Survey Agency of abuse, neglect, or misappropriation of property of a resident, client, or patient.

2. The relative must: (one of the following is required)

- a. have resigned from full-time or part-time employment specifically to provide PDN services to the member; or
- b. have changed from full-time employment to part-time employment resulting in less compensation in order to provide PDN services to the member; or
- c. have taken a leave of absence without pay from employment in order to provide PDN services to the member; or

96.04 COVERED SERVICES (cont)

- d. have incurred substantial expenses by providing PDN services to the member; or
- e. be needed to provide an adequate number of qualified nurses to meet the member's plan of care because of labor conditions or intermittent hours of care.

To apply for coverage under this Section, contact the Director, Bureau of Elder and Adult Services, 11 State House Station, Augusta, ME 04333-0011.

~~Monthly Nursing Service for Levels II and III. Once each month, comprehensive nursing services shall be provided to each Level II and III member. This service shall include a health assessment, as well as any other nursing services that are required/authorized in the plan of care. If the member requires any additional nursing services during the month, those services will be reimbursed as registered nursing services. The monthly health assessment may be billed no more than once per month. The frequency of the monthly health assessment may be reduced to once per quarter if recommended by the RN conducting the health assessment and determined appropriate following review with the HCCA and other appropriate persons involved in implementing the plan of care. This does not eliminate the need for the member to receive a monthly registered nursing service. For those receiving home and community benefits for members with mental retardation as allowed in 96.05(L) or Level I nursing services, monthly health assessment will generally not be necessary but will be determined by the clinical judgment of the RN assessor determining eligibility.~~

- C. Personal Care Services (PCS). For members under the age of 21, excluding those receiving care under the family provider option, PCS must be ordered by a physician and delivered under a plan of care prepared by the PDN provider and signed by the physician.

For members age 21 and over, and for those under age 21 receiving care under the family provider option, PCS must be authorized by the Department, or its Assessing Services Agency, and specified in the authorized plan of care.

As a general rule, there shall be no more than one (1) personal care staff member delivering services at a time. If the Department, or its ASA, (or the physician for individuals under age 21) determines that an individual, based upon his/her health status, requires more than one personal care staff member to perform a specific ADL task (e.g. to transfer a large person), then this can be authorized and specified in the plan of care.

Personal care services include services related to a member's physical requirements for assistance with the activities of daily living, including assistance with related health maintenance activities.

Additionally, when authorized and specified in the Department, or ASA authorized plan of care, PCS may include IADL and related health maintenance tasks, which are directly related to the member's plan of care. These tasks must be performed in conjunction with direct care to the member. Health maintenance and IADL tasks are those that would otherwise be normally performed by the member if he or she were physically or cognitively able to do so. It must also be

96.04 COVERED SERVICES (cont)

established that there is no family member or other person available to assist with these tasks. A child or infant shall not qualify for coverage of IADL tasks because an infant or child does not normally perform these tasks. Coverage of IADL tasks is provided to assist individuals with disabilities to live independently in the community. ~~Excluding Level I services, IADL tasks may constitute up to, but shall not exceed, two thirds of the total weekly time authorized for personal care services. At least one third of the total weekly time authorized for personal care assistance shall be for ADL assistance. For Level I services, IADL tasks may constitute up to, but shall not exceed, 10 hours per month of authorized personal care services.~~ IADL services may be authorized and covered only if the member also requires ADL services. IADL services are not covered as stand-alone personal care services; these may be covered only in combination with ADL services. The maximum hours per week allowed for IADL tasks for levels I through III is as follows: Level I is two hours; Level II is three hours; and Level III is four hours. ADL and IADL tasks, and the allotted hours, must be specified and authorized in the plan of care.

Certified nursing assistants, home health aides, or personal care assistants may transport a member only to carry out necessary covered services in the member's plan of care. Escort services may be provided only when a member is unable to be transported alone, there are no other resources (family or friends) available for assistance, and the transportation agency can document that the agency is unable to meet the request for service.

Such documentation must be included in the member's record. Coverage is not available to reimburse for mileage or vehicle usage under this Section. Only the provider's services are covered.

Personal care services shall be provided, as appropriate, by a:

1. Home health aide;
2. Certified nursing assistant; or
3. Personal care assistant.

Personal care services shall not be covered when delivered by a spouse of the member, the parents or stepparents of a minor child, or a legally responsible relative.

The task time allowances set forth in Appendix 1 must be used to authorize the time covered to complete covered and authorized ADL ~~and IADL~~ tasks for the plan of care. For members age 21 and over, and those receiving care under the family provider services option the ~~Authorized Agent~~ ASA shall abide by Appendix 1. For members under age 21, the PDN provider shall abide by Appendix 1. These allowances reflect the time normally allowed to accomplish the listed tasks. The ~~Authorized Agent~~ ASA and the PDN provider will use these allowances when authorizing a member's care plan. If these times are not sufficient when considered in light of a member's ~~extraordinary~~ unique circumstances as identified and documented by the ~~Authorized Agent~~ ASA or the PDN Provider, the ~~Authorized Agent~~ ASA or the PDN Provider may make an appropriate adjustment as long as the authorized hours do not exceed the established limits for the member's assessed level of care.

- D. The "PCA supervisit" is a one-hour visit to deliver personal care services and health maintenance activities to a member, no more than once per day. This service may be authorized up to seven days per week. If the member requires more than one hour of personal care services on a given day, then

96.04 COVERED SERVICES (cont)

the regular PCA services must be billed with the half-hour unit procedure codes, and the one-hour visit procedure code shall not be used. This is not a covered service under the family provider services option defined in Section 96.01-23.

- E. Venipuncture Services. Venipuncture shall be covered when it is the only identified nursing need and is required on a regular basis, as ordered by the physician. An RN or LPN must deliver venipuncture services. PCS are not covered services under venipuncture services. If the member requires additional services, then he/she must meet (at least) the eligibility requirements for Level II or III. If the member qualifies for Level II or III then all services including venipuncture services shall be authorized and delivered under Level II or III.
- F. Medication and Venipuncture Services. Medication services are those services ~~that~~ which are directly related to the administration and/or monitoring of medications intended for the treatment and management of mental illness in the context of community support services for people with severe and disabling mental illness. Monitoring services may include venipuncture services for members under this Section. A psychiatric nurse or a registered professional nurse must deliver these services. PCS are not covered services under this Section 96.04(F). If the member requires additional services, then he/she must meet (at least) the eligibility requirements for the level II of care. If the member qualifies for Level II or III then all services including medication services shall be authorized and delivered under the Level II or III.
- G. Interpreter Services. Interpreter services for the hearing impaired and for foreign languages are available as described in Chapter I.
- H. Multiple patient nursing services. For nursing services (RN and LPN) under levels IV and V, the multiple patient rate must be used whenever more than one patient is served in the same home or building, during the same visit. The rate is 66% of the regular rate per member served. Whenever one or more of the patients served is not a MaineCare member, the multiple patient rate shall still apply to the MaineCare member. Providers must bill with the Chapter III procedure codes designated for multiple patients.
- I. Members who are receiving any of the following MaineCare services may only access nursing services under this Section, and are prohibited from receiving personal care services under this Section since the personal care services are provided under these Sections: Section 2, Adult Family Care Services; Section 6, Assisted Living Services; Section 12, Consumer Directed Attendant Care Services; Section 22, Home and Community Benefits for the Physically Disabled; Section 97, Private Non-Medical Institution Services; and Section 21, Home and Community-Based Waiver Services for Members with Mental Retardation.

96.05 NON-COVERED SERVICES

The following services are not reimbursable under this Section:

- A. Services for which the cost exceeds the limits described in this Section, except as described in 96.03(A);

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96.05 **NON-COVERED SERVICES** (cont)

- B. Psychiatric nursing services, except as described under 96.04;
- C. Those services that ~~which~~ can be reasonably obtained by the member outside his/her place of residence;
- D. Unless qualified for the “special circumstances nursing” (see Section 96.04(B)), ~~N~~nursing services when provided by the member’s husband or wife, natural or adoptive parent, child, or sibling, stepparent, stepchild, stepbrother or stepsister, father in law, mother in law, son in law, daughter in law, brother in law, sister in law, grandparent or grandchild, spouse of grandparent or grandchild or any person sharing a common abode as part of a single family unit;
- E. Personal care services provided by a spouse of the member, the parents or stepparents of a minor child, or a legally responsible relative;
- F. Homemaker and chore services not directly related to medical necessity. Homemaker and chore services are covered in this Section only as authorized by the ASA in the plan of care when required;
- G. Services in an ICF-MR, nursing facility or hospital;
- H. Services to members receiving any Home and Community Benefits for the Elderly, or Adults with Disabilities (nursing and personal care services are covered under these waiver benefits);
- I. Escorting members outside of the home, except as described in Section 96.01-3 or 96.04(C);
- J. Custodial care or respite care;
- K. Personal care services delivered in an Adult Family Care Home setting or other licensed Assisted Living Facility that ~~which~~ is reimbursed for providing personal care services. It is the responsibility of the AFCH or assisted living provider to deliver personal care services;
- L. Personal care services (PCS) may not be provided to members receiving Home and Community Benefits for Persons with Mental Retardation or Home and Community Benefits for the Physically Disabled. PCS is a covered service under these Waivers. These members may receive nursing services only under this Section;
- M. Supervisory visits made for the purpose of supervising home health aides, certified nursing assistants or personal care assistants;
- N. Services which are not authorized by the plan of care; and
- O. Services in excess of 40 hours per week, provided by an individual PCA, home health aide or certified nursing assistant, for an individual member.

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96.06 POLICIES AND PROCEDURES

96.06-1 Eligibility Determination

Applicants for services under this Section must meet the eligibility requirements set forth in Section 96.02. An eligibility assessment, using the Department's approved MED assessment form, shall be conducted by the Department, the ASA, or the PDN provider, as applicable.

Eligibility for individuals under the age of 21, and for ~~M~~medication ~~S~~services or ~~V~~venipuncture ~~S~~services, and excluding all seeking services under the family provider services option, shall be determined by the PDN provider, in accordance with the requirements of Section 96.02 and the MED form.

These services require prior classification by the Department. All other PDN/PCS services, for members age 21 and over, and those requesting services under the family provider option, require eligibility determination and prior authorization by the ASA.

Applicants ages 18 and over who meet the NF medical eligibility criteria also qualify for Home and Community Benefits. These benefits may provide a greater array and quantity of services than otherwise available under this Section 96; therefore, applicants must be assessed to determine whether they qualify for NF level of care. Members are prohibited from receiving Home and Community Benefits and services under this Section simultaneously, except as described in Section 96.05(L).

- A. If financial eligibility for MaineCare has not been determined, the applicant, family member or guardian must be referred to the regional office of the Bureau of Family Independence, concurrent with the relevant medical eligibility determination process.
- B. The Department, or its ASA, shall conduct a medical eligibility assessment using the Department's approved MED assessment form. The individual conducting the assessment shall be a registered nurse (RN) and will be trained in conducting assessments and developing an authorized plan of care with the Department's approved tool. The RN assessor's findings and scores recorded in the MED form shall be determinative in establishing eligibility for services and the authorized plan of care.
- C. The PDN provider shall develop a nursing plan of care, which shall be reviewed and signed by the member's physician. It shall include the personal care and nursing services authorized by the ASA or the Department, and the nursing plan signed by the member's physician.
- D. The anticipated costs of services under this Section to be provided under the authorized plan of care must conform to the limits set forth in Section 96.03.
- E. An individual's specific needs for medical services must be reviewed and approved by the member's physician at least every sixty-two (62) days, and so documented in the medical record and nursing plan of care by the RN's.

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96.06 **POLICIES AND PROCEDURES (cont)**

1. Members age 21 and over, and members requesting services under the family provider option. Applicants, age 21 and over, and members requesting services under the family provider option, who meet the eligibility criteria for PDN services, as set forth in Section 96.02, and as documented by the Department's approved MED assessment form, shall:
 - a. Be assigned, by the ASA, to the appropriate level of care, and receive an authorized plan of care based upon the scores, timeframes, findings and covered services recorded in the MED assessment. The covered services to be provided in accordance with the authorized plan of care shall: 1) not exceed the established financial caps; 2) be prior authorized by the Department or its ASA; and 3) be under the direction of the member's physician for the nursing plan of care.
 - b. The assessor shall approve a classification period for the member, based upon the scores, timeframes and needs identified in the MED assessment for the covered services, and the assessor's clinical judgment. A classification period shall not exceed twelve (12) months.
 - c. The assessor shall forward the completed assessment packet to the Department's authorized Home Care Coordinating Agency (HCCA) within seventy-two (72) hours of the medical eligibility determination and authorization of the plan of care.
 - d. The HCCA shall contact the member within twenty-four (24) hours of receipt of the MED assessment and authorized plan of care. The HCCA shall assist the ~~consumer~~ member with locating providers and obtaining authorized services. The HCCA shall implement and coordinate services with the provider agency or independent contractor using service authorizations, as well as, monitor service utilization and assure compliance with this policy. In the event a member experiences an emergency or an acute episode, the HCCA has the authority to adjust the frequency of services under the authorized care plan, up to 15%, as long as the total authorized care plan hours are not exceeded, in order to meet the member's needs. A significant or long-term change requires a reassessment by the ASA.
 - e. The provider or independent contractor shall request authorization from the Department's Authorized Agent for any change in the authorized plan of care. The Authorized Agent shall be responsible to assure that the authorized plan of care shall not exceed the financial "cap" established by the Department.
 - f. If Level V services are requested, a ~~C~~complete standardized referral requests for Level V services ~~for individuals age 21 and over~~ must be submitted to the Department or the ASA.

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96.06 POLICIES AND PROCEDURES (cont)

2. Members under age 21, excluding those requesting services under the family provider option..
 - a. ~~Services for individuals under age 21~~ require prior classification by the Department. The Department shall approve a classification period, not to exceed one (1) year.
 - b. An individual under age 21, who does not meet the eligibility criteria for PDN services as set forth in Section 96.02, may be reviewed under Prevention, Health Promotion, and Optional Treatment Services. If the provider determines that services are medically necessary pursuant to the criteria of Prevention, Health Promotion, and Optional Treatment Services, then services shall be provided in accordance with a plan of care and billed under this Section.
 - c. If a provider determines that any of the requested services, for an individual under age 21, are medically necessary, but are not available from that provider, the provider shall notify the family in writing (in the Department's approved notice format) which services are not available from that provider. A copy of the letter shall be sent to the Department's Prevention, Health Promotion, and Optional Treatment Services staff, and Prevention, Health Promotion, and Optional Treatment Services staff shall offer to assist the member in locating other providers.
 - d. If the provider determines that the PDN/PCS services are not medically necessary, then the provider shall notify (using a notice format approved by the Department) the family in writing of which services will be provided and which services will not be provided, or provided only on a reduced basis. The notice shall contain an understandable explanation of the reasons and inform them of their appeal rights and of Prevention, Health Promotion, and Optional Treatment Services. A copy of any denial/reduction notice shall be sent to the Prevention, Health Promotion, and Optional Treatment Services. Prevention, Health Promotion, and Optional Treatment Services will then offer to assist the family to see what other services may be provided to meet the child's needs.
 - e. The private duty nursing services provider shall develop a nursing plan of care and an authorized plan of care.
 - f. The anticipated costs of services to be provided under the plan of care must conform to the limits set forth in Section 96.03. The costs of physical therapy, occupational therapy, speech and hearing services shall not be included in the calculation of either the average annual cost of institutional services or the cost of PDN services required by the individual.

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96.06 POLICIES AND PROCEDURES (cont)

- g. The PDN/PCS provider shall obtain the signature of the physician on the plan of care or a physician's order for private duty nursing and personal care services and for the medical treatment plan. This shall be made available to the Department or its Authorized Agent upon request. Services must also be authorized by the Department or its Authorized Agent.
- h. For services to individuals under age 21, as well as individuals classified for venipuncture services and medication services, but excluding those receiving services under the family provider option, the eligibility assessment form and the plan of care shall be maintained in the member's medical record, available upon request for review by the Department. The provider must submit a copy of the medical eligibility determination form to the Department.
- i. The provider shall be responsible for assuring that the plan of care shall not exceed the financial "cap" established by the Department.

96.06-2 Reclassification and Continued Services

- A. For all members under this Section, in order for the reimbursement of services to continue uninterrupted beyond the approved classification period, a reassessment and prior authorization of services is required and must be conducted within the timeframe of 5 days prior to and no later than the reclassification date.

For members under the age of 21, as well as members classified for venipuncture services and medication services, but excluding those receiving care under the family provider option, the MED assessment tool shall be submitted to the Bureau of Medical Services, Quality Improvement Division within seventy-two (72) hours of completion of the MED form, for initial assessments or reassessments. MaineCare payment ends with the reassessment date, also known as the classification end date.

- B. An individual's specific needs for medical services are reviewed at least every sixty-two (62) days, and so documented in the medical record and nursing plan of care by the RN.

96.06-3 **Family Provider Service Option.** All requirements of Section 96 apply to the family provider service option unless exempted specifically in this subsection, or elsewhere in this Section. This option allows, under certain conditions specified below, a MaineCare member (or a family member on his or her behalf,) to solely manage the member's authorized personal care services, if the member (or a family member,) is a family provider agency. The management of the personal care services includes: hiring, firing, training, maintaining records and scheduling the personal care assistant(s).

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96.06 **POLICIES AND PROCEDURES (cont)**

A. The following provisions apply:

1. The MaineCare member, or his or her family member (see below), as applicable, must be age 21 years or older, and register with the Department as a “personal care agency,” pursuant to the Department’s Rules and Regulations Governing In-Home Personal Care and Support Workers.
2. A family member related by blood, marriage or adoption, or a significant other in a committed partnership, must register as the personal care agency in order to manage the personal care services on behalf of the MaineCare member, if the member does not have the ability, or does not meet the required standards for cognitive capacity, or otherwise does not desire to manage his or her own care.
3. The MaineCare member must meet the minimum standards for cognitive capacity as defined in Section 96.01-26, in order to be the family provider agency.
4. For children and youth under age 21 years, a parent or guardian may be the family provider agency, if the child has all required medical eligibility determination (MED) assessments performed by the ASA and management performed by the HCCA, as is required of all other members using this family provider option. (Note: under other Sections of this rule, children’s services do not go through the ASA and HCCA)
5. Participation is subject to the approval (and ongoing approval) of the HCCA under that authorized agent’s contractual quality assurance responsibilities.
6. The family provider agency may manage personal care services for up to two family members.
7. The family provider agency may hire a family member to deliver the personal care services, with the exception of the MaineCare member’s spouse, or the parent (including stepparent) of a minor child who is a MaineCare member. Refer to Federal regulation 42 CFR 440.167, and the State Medicaid Manual, Section 4480, Personal Care Services (prohibits the coverage of personal care services delivered by these legally responsible family members.)
8. The adult who is registered as the personal care agency will not be paid to provide care to the member.
9. A member’s guardian will not be paid to provide care to the member.

B. The family provider agency must:

1. check the CNA registry and conduct a criminal history background check for any individual hired as a personal care assistant and not employ an individual who is prohibited from employment under Title 22 MRSA §1717(3);

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96.06 **POLICIES AND PROCEDURES (cont)**

2. use a fiscal intermediary payroll agent that has been approved by the HCCA;
3. receive authorization from the ASA, including an authorized plan of care;
4. implement the authorized plan of care;
5. comply with HCCA quality assurance oversight activities and visits; and
6. comply with all HCCA contract requirements. Failure to comply will result in termination of the member's participation in the family provider service option by the HCCA.

C. As part of the family provider services option, the Home Care Coordination Agency must:

1. check the CNA Registry and conduct a criminal background check on the individual who registers as a personal care agency;
2. establish a monthly cost limit based upon the authorized plan of care;
3. manage the member's authorized professional services (i.e., RN services);
4. contract with a fiscal intermediary;
5. recoup funds paid for services that were not delivered in compliance with this section; and
6. serve as the Department's authorized HCCA for members under 21 who are receiving services under the family provider services option as defined in section 96.01-23.

D. As part of the family provider services option, the Assessing Services Agency must serve as the Department's authorized agent for members under age 21 who are receiving services under the family provider services option as defined in 96.01-23.

96.06-34 Discharge Notification

- A. A provider serving children under age 21, and members receiving venipuncture services and medication services, must notify the Department within forty-eight (48) hours of discharging a member from care.
- B. A provider serving members age 21 and over must notify the HCCA within forty-eight (48) hours of discharging a member from care.

96.06 **POLICIES AND PROCEDURES** (cont)

96.06-45 Professional and Other Qualified Staff

All professional staff must be conditionally, temporarily, or fully licensed as documented by written evidence from the appropriate governing body. All professional staff must provide services only to the extent permitted by qualified professional staff licensure. Services provided by the following staff are reimbursable under this Section.

A. Registered Professional Nurse

A registered professional nurse employed directly or through a contractual relationship with a home health agency or acting as an individual practitioner may provide Private Duty Nursing Services by virtue of possession of a current license to practice their health care discipline in the state in which the services are performed.

B. Psychiatric Registered Nurse

A registered professional nurse that is licensed by the state or province in which services are provided and has met requirements for approval to practice as an advanced practice psychiatric nurse or is certified as a psychiatric and mental health nurse by the appropriate national accrediting body.

C. Licensed Practical Nurse

A licensed practical nurse employed directly by or through a contractual relationship with a licensed home health agency may provide Private Duty Nursing Services by virtue of possession of a current license to practice their health care discipline in the state in which the services are performed provided they are supervised by a registered professional nurse.

D. Home Health Aide

Any home health aide employed directly by, or acting under a contractual relationship with, a licensed home health agency must have satisfactorily completed a training ~~program~~ for certified nurse assistants consistent with the rules and regulations of the Maine State Board of Nursing. Home health aides employed by a home health agency must also have satisfactorily completed an agency orientation as defined by the Regulations governing the Licensing and Functioning of Home Health Care Services and be listed on the CNA registry. The HHA must meet all applicable state laws and regulations as are currently in effect.

E. Certified Nursing Assistant (CNA)

A CNA employed by, or acting under a contractual relationship with, a licensed home health agency must have satisfactorily completed a training ~~program~~ for certified nurse assistants consistent with, and receive supervision consistent with, the Rules and Regulations of the Maine State Board of Nursing and be listed on the CNA registry. The CNA must meet all applicable state laws and regulations as are currently in effect.

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96.06 POLICIES AND PROCEDURES (cont)

F. Certified Nursing Assistant/Medications

A CNA who meets the requirements in Section 96.06-4(E) above and has satisfactorily completed a Department-approved medication course for Certified Nursing Assistants, consistent with the Rules and Regulations of the Maine State Board of Nursing and be listed on the CNA registry.

G. Personal Care Assistant (PCA)

A PCA must be employed by, or acting under a contractual relationship with a licensed home health agency or a registered personal care agency. The following requirements must be met: To be reimbursed, PCAs must meet either the training requirements or competency determination requirements described below. PCAs, newly employed and providing services after July 1, 2002 must complete the training and examination requirements within six (6) months of employment. A PCA must:

1. Criminal background check and CNA registry check. A provider agency must check the CNA registry and conduct criminal background checks for applicants for positions as PCAs, CNAs or home health aides and must not employ an individual who is prohibited from employment under Title 22 MRSA §1717.
2. Training. A provider agency must verify that a PCA meets one of the training and examination requirements below. An individual without the required training may be hired and reimbursed for delivering personal care services as long as the individual completes training and examination requirements within six months of employment and meets all other requirements. If the individual fails to pass the examination within six months, reimbursement for his or her services must stop until such time as the training and examination requirements are met. A PCA must: (meet one of the following)
 - a. Hold a valid certificate of training for nursing assistants and be listed on the Maine Registry of Certified Nursing Assistants; or
 - b. Hold a valid certificate of training, issued within the past three years, for nurse's aide or home health aide training which meets the standards of the Maine State Board of Nursing- nursing assistant training program; or
 - c. Pass the competency-based examination of didactic and demonstrated skills from the Department's approved personal support specialist curriculum if a CNA whose status on the Maine Registry of Certified Nursing Assistants has lapsed, or an individual who holds a valid certificate of training issued more than three years ago, for nurse's aide or home health aide training which meets the standards of the Maine State Board of Nursing- nursing assistant training program. A certificate of training as a personal care assistant/personal support specialist will be awarded upon the successful passing of this examination; or

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96.06 **POLICIES AND PROCEDURES (cont)**

- d. Hold a valid certificate of training as a personal support specialist/personal care assistant issued as a result of completing the Department-approved personal support specialist training curriculum and passing the competency-base examination of didactic and demonstrated skills. The training course must include at least fifty (50) hours of formal classroom instruction, demonstration, return demonstration, and examination. Tasks covered under this Section must be covered in the training; or
 - e. Be a personal care assistant/personal support specialist who successfully completed a Department-approved curriculum prior to September 1, 2003. Such individuals will be grand fathered as a qualified personal care assistant/PSS; or
 - f. Obtain a waiver from the Department, the ASA, or the HCCA. At their discretion, the Department, the ASA, or the HCCA, may waive training requirements for personal care assistants under the family provider option if the PCA has provided services to the member prior to July 1, 2004 under Section 12, Consumer Directed Attendant Services; Section 22, Home and Community Benefits for the Physically Disabled Services; or the state funded Consumer Directed Home Based Care program, under Section 63, In-home and Community Support Services of the Bureau of Elder & Adult Services Policy Manual. Otherwise, PCAs under the family provider option must meet the training and competency requirements described above.
3. New employee orientation.
- a. A PCA, newly hired to an agency, who meets the Department's PSS/PCA training requirements, must receive an agency orientation. The training and certification documents must be on file in the PCA's personnel file.
 - b. With the exception of family provider option PCAs, a newly hired PCA who does not yet meet the Department's training and examination requirements must undergo an eight (8) hour orientation that reviews the role, responsibilities and tasks of the PCA. The orientation must be completed by the PCA prior to the start of delivering services. The PCA must demonstrate competency to the employing agency in all required tasks prior to being assigned to a member's home.
 - c. A family provider agency must provide adequate orientation for the PCA to meet the needs of the member(s). Adequacy shall be determined by the HCCA. The provision of orientation, including the specific dates and times of training, and the content matter of the orientation must be documented in the member's record.

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96.06 **POLICIES AND PROCEDURES (cont)**

4. Provider agency responsibilities include, but are not limited to the following:
 - a. Assure that PCAs meet the training, competency, and other requirements of this Section. Maintain documentation of how each requirement is met in the PCA's personnel file, including: evidence of orientation, CNA registry check, and criminal background checks, and the verification of credentials including the certificate of training and/or verification of competency.
 - b. Supervisory visits.
 - i. Initial supervisory visit. Supervisory visits shall be made to a member's home prior to the start of PCA services to develop and review with the member the plan of care as authorized by the ASA on the care plan summary and by the HCCA on the service order.
 - ii Scheduled supervisory visits. Excluding the family provider service option, for Level III, IV, and V members, A PCA employed by a provider agency must receive on-site supervision of the implementation of the member's authorized plan of care by the agency employer at least quarterly to verify competency and member satisfaction with the PCA performance of the care plan tasks. For Level I and II members, on-site supervision must be at least once every six (6) months along with quarterly phone calls to the member. More frequent or additional on-site supervision visits of the PCA is at the discretion of the provider agency as governed by its personnel policies and procedures.
 - iii Supervisory visits for the family provider option. PCAs reimbursed under the family provider option must have on-site home supervisory visits by the HCCA to evaluate the condition of the member, implementation of the care plan, and the member's satisfaction with the services. Failure to allow the HCCA on-site visits is grounds for terminating reimbursement to the PCA worker or agency.
 - c. A provider agency must develop and implement written policies and procedures that insure a smoke-free environment. PCAs are not allowed to smoke, consume alcohol, or controlled substances in the member's home or vehicle during work hours.
 - d. A provider agency must develop and implement written policies and procedures that prohibit abuse, neglect or misappropriation of a member's property.

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5. A family member who meets the requirements of this Section may be a PCA and receive reimbursement for delivering personal care services, with the exception of the MaineCare member's spouse, or the parent (including stepparent) of a minor child who is a MaineCare member. Refer to Federal regulation 42 CFR 440.167, and the State Medicaid Manual, Section 4480, Personal Care Services (prohibiting the coverage of personal care services delivered by these legally responsible family members.)
6. The HCCA has the authority to recoup funds for services provided if the sub-contracted provider agency does not provide required documentation to support qualifications of the agency, staff or services billed.
7. The HCCA has the responsibility of ensuring the quality of services and the authority to determine whether a PCA agency has the capacity to comply with all service requirements. Failure to meet standards must result in non-approval or termination of the sub-contract for PCA services.

1. ~~Currently be listed on the Certified Nursing Assistant's Registry, or a CNA whose registry status has lapsed due to inadequate employment in a health care institution may choose to take the competency based examination of didactic and demonstrated skills from any BEAS approved curriculum. Successfully passing this examination will result in the award of certificate of training as a Personal Care Assistant.~~

~~If the competency based examination is not completed successfully, the CNA must:~~

- a. ~~complete a Department approved training curriculum;~~
 - b. ~~provide evidence of satisfactory completion of a basic nurse's aide or home health aide training program meeting the standards of the Maine State Board of Nursing within the past three (3) years; or~~
 - c. ~~Applicants who have completed a basic nurse's aide course or home health aide training program more than three years ago may choose to take the competency based examination of~~
 - ~~— didactic and demonstrated skills from the Department approved curriculum. Successfully passing this examination will result in the award of a certificate of training as a personal care assistant~~
2. ~~The PCA shall complete a Department approved curriculum, which meets the following conditions:~~
 - a. ~~The course must include at least forty (40) hours of formal classroom instruction, demonstration, return demonstration, and examination and must cover the tasks included in this Section.~~

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96.06 **POLICIES AND PROCEDURES (cont)**

- ~~b. The course shall be designed and planned and coordinated by a registered nurse in collaboration with other healthcare professionals.~~
 - ~~c. The candidate must provide evidence of successfully passing a competency-based examination of didactic and demonstrated skills resulting in a certificate of training as a personal care assistant.~~
 - ~~3. A newly hired PCA who does not yet meet the Department's training and examination requirements must undergo an eight (8) hour orientation that reviews the role and responsibilities of a PCA. The orientation must be completed by the PCA prior to the start of delivering services. The PCA must demonstrate competency in all required tasks prior to being assigned to a member's home.~~
 - ~~4. PCAs, newly hired to an agency, who meet the Department's training and/or certification requirements, must receive an agency orientation. The training and certification document must be on file in the individual's personnel file.~~
 - ~~5. Employment or Provider agency responsibilities include, but are not limited to the following:~~
 - ~~a. Providers employing personal care assistants (PCAs) must assure that all PCAs meet the training and competency requirements in this Section. The responsibility for verification of PCA credentials rests with the employer.~~
 - ~~i. Family and household members who are reimbursed for PCA services must comply with the training and competency rules.~~
 - ~~ii. Evidence of orientation, the certificate of training, and/or verification of competency, and the CNA registry check, shall be maintained in the PCA's personnel file.~~
 - ~~b. Providers employing PCAs, CNAs or home health aides working as personal care assistants must assure that the CNA or HHA does not have a notation on the registry of certified nursing assistants for:~~
 - ~~i. Any criminal convictions, except for Class D and Class E convictions over 10 years old that did not involve as a victim of the act a patient, client, or resident of a health care entity; or~~
 - ~~ii. any specific documented findings by the State Survey Agency of abuse, neglect, or misappropriation of property of a resident, client, or patient.~~

96.06 POLICIES AND PROCEDURES (cont)

- ~~iii. Providers must develop and implement personnel policies that insure a smoke free environment. PCAs are not allowed to smoke, use alcohol, or controlled substances in the member's home or vehicle during work hours.~~
- ~~iv. Supervisory visits shall be made to a member's home prior to the start of PCA services to develop and review with the consumer the plan of care as authorized by the Assessing Services Agency on the care plan summary and by the Home Care Coordinating Agency on the service order.~~
- ~~v. PCAs employed by agencies must receive on-site supervision of the implementation of the Level III and Level V member's authorized plan of care by their employer at least quarterly to verify competency and member satisfaction with the PCA performance in meeting the care plan tasks. For Level I and Level II members, on-site supervision must be at least once every six (6) months with quarterly phone calls to the member. Ongoing direct on-site supervision of the PCA is up to the discretion of the provider agency as governed by its personnel policies and procedures.~~
- ~~c. Family members reimbursed as PCAs must have on-site home supervisory visits by the HCCA to evaluate PCA competence in implementing the care plan and member satisfaction. Failure to allow the HCCA on-site visits is grounds for terminating reimbursement to the PCA worker or agency.~~
- ~~d. Each personal care assistant's personnel record must include:
 - ~~i. which of the criteria in this Section, if applicable, were met for certifying the PCA; and~~
 - ~~ii. Documentation of the demonstration of competency that includes the scope of the demonstration and the signature of the individual certifying competency on Department approved forms.~~~~
- ~~e. An agency may employ a family member of the MaineCare member to be a PCA, except for: the spouse of the member, the parents or stepparents of a minor child, or a legally responsible relative. Coverage and reimbursement for services provided by any of these legally responsible relatives is prohibited.~~
- ~~f. The HCCA has the authority to recoup funds for services provided if the sub-contracted agency does not provide required documentation to support qualifications of the agency, staff or services billed.~~

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96.06 **POLICIES AND PROCEDURES** (cont)

- ~~g. The HCCA has the responsibility of ensuring the quality of services and the authority to determine whether a PCA agency has the capacity to comply with all service requirements. Failure to meet standards must result in non-approval or termination of the sub-contract for PCA services.~~

H. Fiscal Intermediary

The Fiscal Intermediary acts as an agent of the employer in accordance with Section 3504 of the Federal Internal Revenue Service Code and Internal Revenue Service Revenue Procedure 70-6 in matters related to the employment of support workers and purchases of other support services or goods. The use of a FI is required under the family provider service option.

96.06-~~56~~ Member's Records

A. Authorized Agent, Provider, and sub-contracted Providers, Records

There shall be a specific record for each member which shall include the following:

1. Member's name, address, phone number, emergency contact, birth date;
2. The member's medical eligibility determination form, release of information, authorized plan of care and copies of the eligibility determination notice and service authorizations issued by the Home Care Coordinating Agency for members over age 21;
3. Names and telephone numbers of the persons to call in case of an emergency or for advice or information. This information must be readily available to the HHAs, CNAs, PCAs and other in-home care workers;
4. The plan of care which specifies the tasks and the schedule of tasks to be completed by the PCA, CNA or HHA and authorized services;
5. Entrance and exit times, and total hours spent in the home for each visit by each nurse, PCA, HHA, and CNA; and
6. Progress notes reflecting changes in the member's condition, needs, communications with the member, other information about the member, and contacts with the HCCA or provider agency. Progress notes must be signed and dated by the person entering the note.

B. Authorized Plan of Care

1. The authorized plan of care must indicate the type of services to be provided to the member, specifying who will perform the service, the number of hours per week, specifying the begin and end dates, and specifying the tasks and reasons for the service.

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96.06 **POLICIES AND PROCEDURES** (cont)

For all members age 21 and over, excluding those classified for medication services or venipuncture services, and for those members under age 21 receiving care under the family provider option under this Section, the Assessing Services Agency (ASA) has the authority to determine and authorize the plan of care.

2. Members may receive Medicare covered services, as applicable, during the same time period they receive MaineCare covered PDN/PCS. The authorized plan of care must identify the types and service delivery levels of all other home care services to be provided to the member whether or not the services are reimbursable by MaineCare. These additional home care services might be provided by such individuals as homemakers, personal care attendants and companions. These additional services shall include, but not be limited to, case management, home-delivered meals, physical therapy, speech therapy, occupational therapy, MSW services and hospice.

C. Nursing Treatment Plan of Care

The licensed home health agency provider or independent contractor shall obtain the signature of the physician on the nursing plan of care or a physician's order for nursing treatments and procedures at least every 62 days, medications, medical treatment plan and frequency and level of personal care services. This shall be made available to the Department or its Authorized Agent upon request. Covered services must be authorized by the Department or the ASA. Content of the nursing treatment plan must include the following information:

1. All pertinent diagnoses, including mental status;
2. All services, supplies, and equipment ordered;
3. The level of care, frequency and number of hours to be provided;
4. Prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, safety measures to protect against injury, and any additional items the PDN services provider or physician choose to include. Orders for care must indicate a specific range in the frequency and number of hours. Orders may not be open-ended or "as needed;"
5. The nursing plan of care, and physician's orders for ~~or nursing treatments and procedures~~ plan of care must be reviewed and signed by the member's physician as required by the Department in this Section at least every 62 days.

D. Written Progress Notes for Services Delivered by a Direct Care Provider (includes HCCA sub-contracted agencies)

Written progress notes shall contain:

1. The service provided, date, and by whom;

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96.06 **POLICIES AND PROCEDURES** (cont)

2. Entrance and exit times of nurse's, home health aide's, certified nursing assistant's and personal care assistant's visits and total hours spent in the home for each visit. Exclude travel time [unless provided as a service as described in this Section];
3. a written service plan that shows specific tasks to be completed and the schedule for completion of those tasks;
4. Progress toward the achievement of long and short range goals. Include explanation when goals are not achieved as expected;
5. Signature of the service provider; and
6. Full account of any unusual condition or unexpected event, dated and documented.

E. Written Progress Notes for the HCCA

Written progress notes for the HCCA must contain:

1. Date and time of every contact with the member and by whom; and
2. Progress toward the achievement of long and short range goals. Include explanation when the goals are not met as expected; and
3. Signature and date of the HCCA staff member entering the note; and
4. Full account of any unusual condition or unexpected event, dated and documented; and
5. All entries must be signed by the individual who performed the service. Authorized and valid electronic signatures are acceptable.

~~F. Access to Records~~

~~Member records and any other files pertaining to services provided through this policy and reimbursed by MaineCare shall be available, without additional charge, for review by the Surveillance and Utilization Review Unit.~~

96.06-67 Surveillance and Utilization Review

All providers are subject to the Department's Surveillance and Utilization Review activities. Refer to Chapter I, General Administrative Policies and Procedures for rules governing these functions.

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96.06 **POLICIES AND PROCEDURES** (cont)

96.06-78 Member Appeals

A member has the right to appeal in writing or verbally any decision made by the Department or its Authorized Agent, to reduce, deny or terminate services provided under this benefit program. In order for services to continue during the appeal process, a request must be received by the Department within ten (10) days of the notice to reduce or terminate services. Otherwise, an individual has sixty (60) days in which to appeal a decision. Members shall be informed of their right to request an Administrative Hearing in accordance with this Section and Chapter I of this manual.

- A. An appeal for members, aged 21 and over, and those under age 21 receiving care under the family provider services option, must be requested in writing or verbally to:

Director
Bureau of Elder and Adult Services
c/o Hearings
11 State House Station
Augusta, ME 04333-0011

- B. For members under the age of 21, and for all members classified for medication services or venipuncture services, but excluding those receiving care under the family provider services option, an appeal must be made by the member or his or her representative, in writing or verbally, for a hearing to:

Director
Bureau of Medical Services
Department of Health and Human Services
11 State House Station
Augusta, Maine 04333-0011

For the purposes of determining when a hearing was requested, the date of the fair hearing request shall be the date on which the Director receives the request for a hearing. The date a verbal request for a fair hearing is made is considered the date of the request for the hearing. The Bureau of Medical Services may also request that a verbal request for an administrative hearing be followed up in writing, but may not delay or deny a request on the basis that a written follow-up has not been received.

96.07 **REIMBURSEMENT**

96.07-1 Reimbursement for Private Duty Nursing and Personal Care Services.

Reimbursement will be made on the basis of a partial hour rate as specified in Chapter III of this Section and shall be the lower of:

- A. The amount listed in Chapter III, Section 96, Allowances for Private Duty Nursing and Personal Care Services, or
- B. The provider's usual and customary charge.

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96.06 **POLICIES AND PROCEDURES** (cont)

In accordance with Chapter I of the MaineCare Benefits Manual, it is the responsibility of the provider to seek payment from any other sources that are available for payment of the rendered service prior to billing the MaineCare Program.

96.07-2 Licensed Home Health Care Agencies

In order to qualify for reimbursement under this Section as a Home Health Care Agency, the Home Health Agency must have in effect a license pursuant to the Department's Regulations Governing the Licensing and Functioning of Home Health Care Services, as are currently in effect. These standards are incorporated into this Section by reference as if set out fully herein.

96.07-3 Registered Personal Care Agency

In order to qualify for reimbursement under this Section as a Personal Care Agency, the Agency must have in effect a registration pursuant to the Department's Rules and Regulations Governing In-Home Personal Care and Support Workers, as are currently in effect.

96.07-4 Family Provider Service Option Rates

The rates for family provider services consist of three components:

- a) PCA services rate, which is the portion of the family provider services rate that is designated as the PCA's gross hourly wage for authorized care provided by the family provider.
- b) Family provider expense component, which is the portion of the family provider services rate designated for the mandated employer's share of Social Security, Federal and State unemployment taxes, Medicare, and Workers' Compensation insurance premiums.
- c) Administrative rate, which is the fee paid to the fiscal intermediary for payroll services.

6.08 **COPAYMENT**

96.08-1 Copayment Amount

- A. A copayment will be charged to each MaineCare member receiving services. The amount of the copayment shall not exceed \$3.00 per day for services provided, according to the following schedule:

MaineCare Payment for Service	Member Copayment
\$10.00 or less	\$.50
\$10.01 - 25.00	\$1.00
\$25.01 - 50.00	\$2.00
\$50.01 or more	\$3.00

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96.06 **POLICIES AND PROCEDURES (cont)**

- B. The member shall be responsible for copayments up to \$5.00 per month whether the copayment has been paid or not. After the \$5.00 cap has been reached, the member shall not be required to make additional copayments and the provider shall receive full MaineCare reimbursement for covered services.

Providers are subject to the Department's copayment requirements. Refer to Chapter I, General Administrative Policies and Procedures for rules governing copayment requirements, exemptions and dispute resolution.

96.09 **BILLING INSTRUCTIONS**

- A. Billing must be accomplished in accordance with the Department's billing requirements found in the "Billing Instructions for Home Health Agencies".
- B. In order to receive full MaineCare reimbursement for claims submitted for a service that is defined as an exemption in Chapter I, refer to the billing instructions distributed by the Department and to Chapter I, General Administrative Policies and Procedures.
- C. All services provided on the same day shall be submitted on the same claim form for MaineCare reimbursement.
- D. Billing for all PDN/PCS delivered to individuals age 21 and over, and for those under age 21 receiving care under the family provider option, and excluding members whose level of care is Level VI or Level VII, shall be submitted to the Home Care Coordinating Agency for reimbursement. The HCCA shall only reimburse services provided according to the ASA's authorized plan of care.

Billing for services delivered to children under age 21, excluding those receiving care under the family provider option, and for all Level VI and Level VII ~~venipuncture services, and for all medication~~ services, shall be submitted to the Department.

Appendix #1
TASK TIME ALLOWANCES

ADL = Activities of Daily Living				
Activity	Definitions	Time Estimates		Considerations
Bed Mobility	How person moves to and from lying position, turns side to side and positions body while in bed.	5 – 10 minutes		Positioning supports, cognition, pain, disability level
Transfer	How person moves between surfaces – to/from: bed, chair, wheelchair, standing position (EXCLUDE to/from bath/toilet).	5 – 10 minutes		Use of slide board, gait belt, swivel aid, supervision needed, positioning after transfer, cognition
		up to 15 minutes		Mechanical lift transfer
Locomotion	How person moves between locations in his/her room and other areas on same floor. If in wheel- chair, self-sufficiency once in chair.	5 - 15 minutes (Document time and number of times done in POC)		Disability level, type of aids used, cognition, pain
Dressing & Undressing	How person puts on, fastens and takes off all items of street clothing, including donning/removing prosthesis.	20 - 45 minutes		Supervision, disability, cognition, pain, type of clothing, type of prosthesis
Eating	How person eats and drinks (regardless of skill)	5 minutes 30 minutes 30 minutes		Set up, cut food and place utensils Individual is fed Supervision of activity due to swallowing, chewing, cognition issues
Toilet Use	How person uses the toilet room (or commode, bedpan, urinal); transfers on/off toilet, cleanses, changes pad, manages ostomy or catheter and adjusts clothes.	5 -15 minutes/use		Bowel, bladder program, ostomy regimen, catheter regimen, cognition
Personal Hygiene	How person maintains personal hygiene. (EXCLUDE baths and showers)	Washing face, hands, perineum, combing hair, shaving and brushing teeth	20 min/day	<i>Disability level, pain, cognition, adaptive equipment.</i>
		Shampoo (only if done separately)	15 min up to 3 times/week	
		Nail Care	20 min/week	
Walking	a. How person walks for exercise only b. How person walks around own room c. How person walks within home d. How person walks outside	Document time and number of times in POC, and level of assistance needed.		Disability, cognition, pain, mode of ambulation (cane), prosthesis needed for walking
Bathing	How person takes full-body bath/shower, sponge bath (EXCLUDE washing of back, hair), and transfers in/out of tub/shower	15 - 30 minutes		If shower used and shampoo done then consider as part of activity, cognition

Appendix #1
TASK TIME ALLOWANCES

IADL = Instrumental Activities of Daily Living			
<i>Activity</i>	<i>Definitions</i>	<i>Time Estimates</i>	<i>Considerations</i>
Light Meal, Lunch & Snacks	Preparation and clean up	5 — 20 minutes	Consumer Member participation; type of food preparation; number of meals in POC and preparation for more than one meal
Main Meal Preparation	Preparation and clean up of main meal	20 - 40 minutes	Is Meals on Wheels being used? Preparation time for more than one meal and consumer member participation
Light Housework/ Routine Housework	Dusting, picking up living space Kitchen housework—put the groceries away, general cleaning Making/changing beds Total floor care all rooms and bathrooms Garbage/trash disposal Non-routine tasks, outside chores, seasonal	30 min — 1.5 hr/week	Size of environment, consumer member needs and participation, others in household
Grocery Shopping	Preparation of list and purchasing of goods	45 min - 2 hours/week	Other errands included: bills, banking and pharmacy. Distance from home
Laundry	Sort laundry, wash, dry, fold and put away	In-home 30 minutes/load 2 loads/week	Other activities which can be done if laundry is done in the house or apartment
		Out of home 2 hours/week	

Task time allowances are used for the authorization of covered services under this Section. Refer to Section 96.04(C).

These allowances reflect the time normally allowed to accomplish the listed tasks. The Authorized Agent and PDN provider will use these allowances when authorizing a ~~consumer's member's authorized plan of care plan~~. If these times are not sufficient when considered in light of a ~~consumer's extraordinary~~ member's unique circumstances as identified by the Authorized Agent, the Authorized Agent may make an appropriate adjustment as long as the authorized hours do not exceed the limits established for the member's level-of-care.

Appendix #2

Level of Care Caps

Members are assigned to a level of care based upon the eligibility criteria in Section 96.02. Levels of care I through V have financial caps as follows below. Members under the age of 21 years can exceed the caps when it is medically necessary pursuant to the criteria in Section 94, Prevention, Health Promotion and Optional Treatment Services, MaineCare Benefits Manual.

<u>Level I</u>	<u>\$800/month</u>	<u>\$750/month</u>
<u>Level II</u>	<u>\$1,060/month</u>	<u>\$950/month</u>
<u>Level III</u>	<u>\$1,800/month</u>	<u>\$1550/month</u>
<u>Level IV (under 21 years of age, only)</u>	<u>\$4,341/month</u>	<u>\$3,133/month</u>
<u>Level V</u>	<u>\$20,682/month</u>	
<u>Level VIII</u>	<u>\$750/month</u>	

~~Appendix #1~~
~~TASK TIME ALLOWANCES~~

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~~ALLOWANCES FOR~~
~~PRIVATE DUTY NURSING AND PERSONAL CARE SERVICES~~

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ALLOWANCES FOR PRIVATE DUTY NURSING AND PERSONAL CARE SERVICES			
LICENSED HOME HEALTH CARE AGENCY SERVICES PROVIDER AND REGISTERED PERSONAL CARE AGENCIES			
Levels I, II, & III Services - Persons Age 21 +			
B300	Registered Nurse Services - Licensed Agency	\$18.00 <u>\$22.13</u> \$19.00*	per 1/2 hour
B127	Licensed Practical Nurse Services	\$11.76 <u>\$12.63</u> \$12.76*	per 1/2 hour
B128	Home Health Aide Services	\$8.22 <u>\$8.60</u> \$8.69*	per 1/2 hour
B129	Certified Nursing Assistant Services	\$8.22 <u>\$8.60</u> \$8.69*	per 1/2 hour
B301	Ventilator Care Registered Nurse Services - Licensed Agency	\$18.00 \$19.00*	per 1/2 hour
B131	Registered Nurse Monthly Assessment & Services - Licensed Agency	\$30.00 \$30.50*	per 1/2 hour
B132	Registered Nurse Medication Services (severely mentally disabled) - Licensed Agency	\$18.00 <u>\$22.13</u> \$19.00*	per 1/2 hour

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PROC CODE	DESCRIPTION OF SERVICES	MAXIMUM ALLOWANCES	UNIT
B133	Psychiatric Registered Nurse Medication Services (severely mentally disabled) - Licensed Agency	\$30.00 \$22.13 \$30.50*	per 1/2 hour
B134	Licensed Practical Nurse Medication Services (severely mentally disabled)	\$11.76 \$12.63 \$12.76*	per 1/2 hour
B361	Personal Care Assistant Services*	\$7.10 \$7.49 \$7.57*	per 1/2 hour
B365 ⁴	PCA Supervisit*	\$8.88* \$8.79	per ½ hour
<u>B368</u>	<u>Family Provider Personal Care Assistant Services (age 21 and over)</u>	<u>\$3.39</u>	<u>per 15 minutes</u>
Level V Services - Persons Age 21+			
B320	Registered Nurse Services - Licensed Agency	\$18.00 \$18.50 \$19.00*	per 1/2 hour
<u>B369</u>	<u>Registered Nurse Services – Licensed Agency – multiple patients</u>	<u>\$12.21</u>	<u>per 1/2 hour</u>
B137	Licensed Practical Nurse Services	\$11.76 \$12.76* \$12.63	per 1/2 hour
<u>B370</u>	<u>Licensed Practical Nurse Services – multiple patients</u>	<u>\$8.34</u>	<u>per 1/2 hour</u>

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PROC CODE	DESCRIPTION OF SERVICES	MAXIMUM ALLOWANCES	UNIT
B138	Home Health Aide Services	\$8.22 \$8.60 \$8.69*	Per 1/2 hour
B139	Certified Nursing Assistant Services	\$8.22 \$8.60 \$8.69*	Per 1/2 hour
B135	Personal Care Assistant Services*	\$7.10 \$7.49 \$7.57*	per 1/2 hour
B365 ¹	PCA Supervisit*	\$8.88* \$8.79	per 1/2 hour
B321	Ventilator Care Registered Nurse Services - Licensed Agency	\$18.00 \$ \$19.00*	per 1/2 hour
<u>B368</u>	<u>Family Provider Personal Care Assistant Services (age 21 and over)</u>	<u>\$3.39</u>	per <u>15 minutes</u>
Level VI MEDICATION and VENIPUNCTURE Services - for Severely Mentally Disabled Persons Age 21+			
B150	Registered Nurse Medication Services - Licensed Agency	\$18.00 \$22.13 \$19.00*	per 1/2 hour
B151	Psychiatric Registered Nurse Medication Services - Licensed Agency	\$30.00 \$22.13	per 1/2 hour
B152	Licensed Practical Nurse Medication Services	\$11.76 \$12.63 \$12.76*	per 1/2 hour

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Level VII VENIPUNCTURE ONLY Services - Age 21+				
B160	Registered Nurse Venipuncture Only Services - Licensed Agency	\$18.00 <u>\$22.13</u> \$19.00*	per 1/2 hour	
B161	Licensed Practical Nurse Venipuncture Only Services	\$11.76 <u>\$12.63</u> \$12.76*	per 1/2 hour	
Level VIII Services – Persons Age 21+				
<u>B300</u>	<u>Registered Nurse Services – Licensed Agency</u>	<u>\$22.13</u>	<u>Per ½ hour</u>	
<u>B127</u>	<u>Licensed Practical Nurse Services</u>	<u>\$12.63</u>	<u>Per ½ hour</u>	
<u>B132</u>	<u>Registered Nurse Medication Services</u> <u>(severely mentally disabled) – Licensed Agency</u>	<u>\$22.13</u>	<u>per ½ hour</u>	
<u>B133</u>	<u>Psychiatric Registered Nurse Medication Services</u> <u>(severely mentally disabled- Licensed Agency</u>	<u>\$22.13</u>	<u>per ½ hour</u>	
<u>B134</u>	<u>Licensed Practical Nurse Medication Services</u>	<u>\$12.63</u>	<u>per ½ hour</u>	
<u>B150</u>	<u>Registered Nurse Medication Services – Licensed Agency</u>	<u>\$22.13</u>	<u>per ½ hour</u>	

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PROC CODE	DESCRIPTION OF SERVICES	MAXIMUM ALLOWANCES	UNIT
<u>B151</u>	<u>Psychiatric Registered Nurse Medication Services – Licensed Agency</u>	<u>\$22.13</u>	<u>per ½ hour</u>
<u>B152</u>	<u>Licensed Practical Nurse Medication Services</u>	<u>\$12.63</u>	<u>per ½ hour</u>
<u>B160</u>	<u>Registered Nurse Venipuncture Only Services – Licensed Agency</u>	<u>\$22.13</u>	<u>per ½ hour</u>
<u>B161</u>	<u>Licensed Practical Nurse Venipuncture Only Services</u>	<u>\$12.63</u>	<u>per ½ hour</u>
Levels I, II, & III Services - Persons Under Age 21			
B200	Registered Nurse Services - Licensed Agency	\$18.00 <u>\$22.13</u> \$19.00*	per 1/2 hour
B107	Licensed Practical Nurse Services	\$11.76 <u>\$12.63</u> \$12.76*	per 1/2 hour
B108	Home Health Aide Services	\$8.22 <u>\$8.60</u> \$8.69*	per 1/2 hour
B109	Certified Nursing Assistant Services	\$8.22 <u>\$8.60</u> \$8.69*	per 1/2 hour
B201	Ventilator Care Registered Nurse Services – Licensed Agency	\$18.00 \$19.00*	per 1/2 hour

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PROC CODE	DESCRIPTION OF SERVICES	MAXIMUM ALLOWANCES	UNIT
B144	Registered Nurse Monthly Assessment & Services - Licensed Agency	\$30.00 \$30.50*	per 1/2 hour
B362	Personal Care Assistant Services*	\$7.10 \$7.49 \$7.57*	per 1/2 hour
B366 ¹	PCA Supervisit*	\$8.88* \$8.79	per 1/2 hour
<u>B367</u>	<u>Family Provider Personal Care Assistant Services (under age 21)</u>	<u>\$3.39</u>	<u>per 15 minutes</u>
Level IV Services - for Persons Under Age 21			
B240	Registered Nurse Services - Licensed Agency	\$18.00 \$22.13 \$19.00*	per 1/2 hour
<u>B371</u>	<u>Registered Nurse Services - Licensed Agency – multiple patients</u>	<u>\$14.61</u>	per <u>1/2 hour</u>
B112	Licensed Practical Nurse Services	\$11.76 \$12.63 \$12.76*	per 1/2 hour
<u>B372</u>	<u>Licensed Practical Nurse Services – multiple patients</u>	<u>\$8.34</u>	per <u>1/2 hour</u>
B113	Home Health Aide Services	\$8.22 \$8.60 \$8.69*	per 1/2 hour

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PROC CODE	DESCRIPTION OF SERVICES	MAXIMUM ALLOWANCES	UNIT
B114	Certified Nursing Assistant Services	\$8.22 <u>\$8.60</u> \$8.69*	per 1/2 hour
B241	Ventilator Care Registered Nurse Services - Licensed Agency	\$18.00 <u>\$19.00*</u>	per 1/2 hour
B363	Personal Care Assistant Services*	\$7.10 <u>\$7.49</u> <u>\$7.57*</u>	per 1/2 hour
B366 ⁴	PCA Supervisit*	\$8.88* <u>\$8.79</u>	per 1/2 hour
<u>B367</u>	<u>Family Provider Personal Care Assistant Services (under age 21)</u>	<u>\$3.39</u>	per <u>15 minutes</u>
Level V Services - Persons Under Age 21			
B220	Registered Nurse Services - Licensed Agency	\$18.00 <u>\$18.50</u> <u>\$19.00*</u>	per 1/2 hour
<u>B373</u>	<u>Registered Nurse Services - Licensed Agency – multiple patients</u>	<u>\$12.21</u>	per 1/2 hour
B117	Licensed Practical Nurse Services	\$11.76 <u>\$12.63</u> <u>\$12.76*</u>	per 1/2 hour
<u>B374</u>	<u>Licensed Practical Nurse Services – multiple patients</u>	<u>\$8.34</u>	per 1/2 hour

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PROC CODE	DESCRIPTION OF SERVICES	MAXIMUM ALLOWANCES	UNIT
B118	Home Health Aide Services	\$8.22 <u>\$8.60</u> \$8.69*	per 1/2 hour
B119	Certified Nursing Assistant Services	\$8.22 <u>\$8.60</u> \$8.69*	per 1/2 hour
B125	Personal Care Assistant Services*	\$7.10 <u>\$7.49</u> \$7.57*	per 1/2 hour
B366 ⁴	PCA Supervisit*	\$8.88* <u>\$8.79</u>	per 1/2 hour
<u>B367</u>	<u>Family Provider Personal Care Assistant Services (under age 21)</u>	<u>\$3.39</u>	<u>per 15 minutes</u>
PDN/PCS Prevention, Health Promotion, and Optional Treatment Services - for Persons Under Age 21			
B260	Registered Nurse Services - Licensed Agency	\$18.00 <u>\$22.13</u> \$19.00*	per 1/2 hour
B122	Licensed Practical Nurse Services	\$11.76 <u>\$12.63</u> \$12.76*	per 1/2 hour
B123	Home Health Aide Services	\$8.22 <u>\$8.60</u> \$8.69*	per 1/2 hour
B124	Certified Nursing Assistant Services	\$8.22 <u>\$8.60</u> \$8.69*	per 1/2 hour

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B364	Personal Care Assistant Services*	\$7.10 <u>\$7.49</u> \$7.57*	per 1/2 hour
B366 ¹	PCA Supervisit*	\$8.88* <u>\$8.69</u>	per ½ hour
<u>B367</u>	<u>Family Provider Personal Care Assistant Services (under age 21)</u>	<u>\$3.39</u>	<u>per 15 minutes</u>
<u>Level VIII Services – Persons under Age 21</u>			
<u>B200</u>	<u>Registered Nurse Services – Licensed Agency</u>	<u>\$22.13</u>	<u>per ½ hour</u>
<u>B107</u>	<u>Licensed Practical Nurse Services</u>	<u>\$12.63</u>	<u>per ½ hour</u>
INDEPENDENT REGISTERED NURSE			
<u>Level I, II, & III Services Persons Age 21 +</u>			
B126	Registered Nurse Services	\$15.75 <u>\$16.33</u> \$16.50*	per 1/2 hour
B130	Ventilator Care Registered Nurse Services	\$15.75 \$16.50*	per 1/2 hour

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PROC CODE	DESCRIPTION OF SERVICES	MAXIMUM ALLOWANCES	UNIT
B302	Registered Nurse Monthly Assessment & Services	\$18.00 \$19.00*	per 1/2 hour
B303	Registered Nurse Medication Services (severely mentally disabled only)	\$15.75 \$16.33 \$16.50*	per 1/2 hour
B304	Psychiatric Registered Nurse Medication Services (severely mentally disabled only)	\$18.00 \$18.50 \$19.00*	per 1/2 hour
Level V Services - Persons Age 21+			
B136	Registered Nurse Services	\$15.75 \$16.33 \$16.50*	per 1/2 hour
<u>B375</u>	<u>Registered Nurse Services – multiple patients</u>	<u>\$10.78</u>	<u>per 1/2 hour</u>
B140	Ventilator Care Registered Nurse Services	\$15.75 \$16.00 \$16.50*	per 1/2 hour
Level VI MEDICATION and VENIPUNCTURE Services - for Severely Mentally Disabled - Persons Age 21+			
B340	Registered Nurse Medication Services	\$15.75 \$16.33 \$16.50*	per 1/2 hour
B341	Psychiatric Registered Nurse Medication Services	\$18.00 \$18.50 <u>\$22.13</u> <u>\$19.00*</u>	per 1/2 hour

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Level VII VENIPUNCTURE ONLY Services - Age 21+				
B360	Registered Nurse Venipuncture Only Services	\$15.75 <u>\$16.33</u> <u>\$16.50*</u>	per 1/2 hour	
Level VIII Services – Persons Age 21+				
<u>B126</u>	<u>Registered Nurse Services</u>	<u>\$16.33</u>	<u>per ½ hour</u>	
<u>B303</u>	<u>Registered Nurse Medication Services</u> <u>(severely mentally disabled only)</u>	<u>\$16.33</u>	<u>per ½ hour</u>	
<u>B304</u>	<u>Psychiatric Registered Nurse Medication Services</u> <u>(severely mentally disabled only)</u>	<u>\$18.50</u>	<u>per ½ hour</u>	
<u>B340</u>	<u>Registered Nurse Medication Services</u>	<u>\$16.33</u>	<u>per ½ hour</u>	
<u>B341</u>	<u>Psychiatric Registered Nurse Medication Services</u>	<u>\$22.13</u>	<u>per ½ hour</u>	
<u>B360</u>	<u>Registered Nurse Venipuncture Only Services</u>	<u>\$16.33</u>	<u>per ½ hour</u>	
Levels I, II, & III Services - Persons Under Age 21				
B106	Registered Nurse Services	\$15.75 <u>\$16.33</u> <u>\$16.50*</u>	per 1/2 hour	

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B110	Ventilator Care Registered Nurse Services	\$15.75	per 1/2 hour	
B202	Registered Nurse Monthly Assessment & Services	\$18.00 <u>\$19.00*</u>	per 1/2 hour	
Level IV Services - Persons Under Age 21				
B111	Registered Nurse Services	\$15.75 <u>\$16.33</u> <u>\$16.50*</u>	per 1/2 hour	
<u>B376</u>	<u>Registered Nurse Services – multiple patients</u>	<u>\$10.78</u>	<u>per 1/2 hour</u>	
B115	Ventilator Care Registered Nurse Services	\$15.75 <u>\$16.50*</u>	per 1/2 hour	
Level V Services - Persons Under Age 21				
B116	Registered Nurse Services	\$15.75 \$16.50* <u>\$16.00</u>	per 1/2 hour	
<u>B377</u>	<u>Registered Nurse Services – multiple patients</u>	<u>\$10.56</u>	<u>per 1/2 hour</u>	
B120	Ventilator Care Registered Nurse Services	\$15.75 <u>\$16.00</u> <u>\$16.50*</u>	per 1/2 hour	

* Effective for services delivered on or after 7/1/03

* Excluding Family Provider Personal Care Assistant Services

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CHAPTER III

SECTION 96

PRIVATE DUTY NURSING AND PERSONAL CARE SERVICES

6/9/86

PROC CODE	DESCRIPTION OF SERVICES	MAXIMUM ALLOWANCES	UNIT
PDN/PCS Prevention, Health Promotion, and Optional Treatment Services - for Persons Under Age 21			
B121	Registered Nurse Services	\$15.75 \$16.50 *\$16.33	per 1/2 hour
Level VIII Services – Persons Under Age 21			
<u>B106</u>	<u>Registered Nurse Services</u>	<u>\$16.33</u>	<u>per ½ hour</u>

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THE CODES BELOW WILL BE ACTIVATED UPON NOTICE TO PROVIDERS FROM THE DEPARTMENT AND WILL REPLACE THE CODES ABOVE. REIMBURSEMENT RATES WILL NOT BE AFFECTED BY THIS CHANGE.

<u>PDN AGENCY</u>		<u>Maximum Allowance</u>	<u>Unit</u>
T1001	Nursing Assessment/evaluation	\$15.25*	¼ Hour
T1002	RN Services, up to 15 minutes	\$9.25* <u>11.07</u>	¼ Hour
	Psychiatric Registered Nurse Medication Services	\$15.25* <u>11.07</u>	¼ Hour
T1002 TT	RN Services, up to 15 minutes, multiple patients		
T1003	LPN/LVN Services, up to 15 minutes	\$6.13* <u>\$6.32</u>	¼ Hour
T1003 TT	LPN/LVN Services, up to 15 minutes, multiple patients	X 66% of rate	
T1004	Services of a qualified nursing aide, up to 15 minutes	\$4.34* <u>\$4.30</u>	¼ Hour
T1019	Personal Care Services per 15 minutes	\$3.78* <u>\$3.75</u>	¼ Hour
TXXX¹	Personal Care Services "Supervisit"	\$4.44 <u>\$4.40</u>	¼ Hour
T1019 U2	Personal Care Services per 15 minutes, family provider PCS	\$3.39	¼ Hour
<u>PDN INDIVIDUAL PROVIDER</u>			
T1000	Private duty/independent nursing service(s) – licensed, up to 15 minutes	\$8.13* <u>8.17</u>	¼ Hour
T1000 TT	Private duty/independent nursing service(s) – licensed, up to 15 minutes, multiple patients	X 66% of rate	
T1001	Nursing Assessment/evaluations	\$9.25	¼ Hour
	Psychiatric Registered Nurse Medication Services	\$9.25*	¼ Hour
TXXX¹	Personal Care Services "Supervisit"	\$4.44	¼ Hour

¹ The Department will issue updated billing instructions and procedure codes when these new procedure codes become effective to conform with federal HIPAA requirements.

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